

CERTIFICATE OF DEATH

Reg. Dist. No.

02788

2843

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn			
c. LENGTH OF STAY IN 1b 8mo. 3 years 28 days				d. STREET ADDRESS Route 2, Box 54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pearl		First Pearl		Middle Adams		Last Adams	
4. DATE OF DEATH 3		Month 18		Day 19		Year 60	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records	
17. ADDRESS Unknown							
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 023X DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cardiovascular disease (c) Syphilis + Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 --		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/20 , 19 56 , to 3/18 , 19 60 , that I last saw the deceased alive on 3/18 , 19 60 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissman		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.					
DATE SIGNED 3/18/60							
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		Crownsville State Hospital, Md. 3/18/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 3-23-60		22c. NAME OF CEMETERY OR CREMATORY mt Auburn Cem		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE S. O. Wilson		ADDRESS 1000 Brantly		24a. REC'D BY REGISTRAR MAR 24 '60		24b. REGISTRAR'S SIGNATURE Arthur J. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9328

CERTIFICATE OF DEATH

2843



John Arnold

John Arnold

John Arnold

Nov 28

Nov 28

Nov 28

Box 24

Box 24

18

18

18

67

67

67

67

North Carolina

North Carolina

Unknown

Unknown

Hospital records

Unknown

Unknown

John Arnold

John Arnold

John Arnold

John Arnold

X

John Arnold

John Arnold

John Arnold

John Arnold

John Arnold

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2844

CERTIFICATE OF DEATH

02789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Convalescent Home		d. STREET ADDRESS 1822 N. Broadway	
3. NAME OF DECEASED (Type or print) First Louise Middle Lurena Last Anderson		4. DATE OF DEATH Month March Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1891
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No	
17. INFORMANT Pattie Stickland - 1822 N. Broadway		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH ? yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 26, 1958 to March 4, 1960 , that I last saw the deceased alive on February 20, 1960 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James M. Pair M.D. 400 N. Carrollton Avenue March 5, 1960 PHYSICIAN'S NAME (Type) James M. Pair, M.D. Baltimore 23, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		24a. REC'D BY REGISTRAR March 9 '60	
ADDRESS - 802 Madison Avenue, Baltol		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2803

12790

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>610 BURNSIDE ST.</u>				d. STREET ADDRESS <u>610 BURNSIDE ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>A.</u> Last <u>BACHMANN</u>				4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MAX T. BACHMANN</u> Address <u># 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombotic accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>hypertensive cerebrovascular dis</u> DUE TO (c) <u>gen arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>3-9</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>2-29</u> 19 <u>60</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edith Rodler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-10-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edith Rodler</u>				22d. ADDRESS <u>45 Franklin St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-11-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEDAR BURY</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOHIS MD.</u>	
23e. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Son, Annapolis, Md.</u>				23f. ADDRESS		25a. REC'D BY REGISTRAR <u>Arthur L. Kenna</u>	
DATE <u>MAR 14 '60</u>				25b. REGISTRAR'S SIGNATURE			

X

1

0

1

26

STATE OF TEXAS,
COUNTY OF _____

2845

CERTIFICATE OF DEATH

Reg. Dist. No.

02791

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale		c. LENGTH OF STAY IN 1b 35 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 220 Wicklow Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Andrew Baker, SR. Middle Last 		4. DATE OF DEATH Month March 8, Day Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Jan., 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Ret.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Baker		14. MOTHER'S MAIDEN NAME Francis (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-7463	
17. INFORMANT Mrs. Aleatha Baker, Same as 2.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) CORONARY ATHEROSCLEROSIS DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 19 53 , to MARCH 19 60 , that I last saw the deceased alive on 3-2 19 60 , and that death occurred at 7:00AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon C. Perry		ADDRESS (Street, city or town, state) DATE SIGNED 201 Balto. & Anna. Blvd. 3-8-60	
PHYSICIAN'S NAME (Type) Leon C. Perry		Glen Burnie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11 Mar. 1960	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAR 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

102701

2845

CENTRE OF DEATH

THE STATE OF NEW YORK
IN SENATE
JANUARY 1, 1911
REPORT
OF THE
COMMISSIONER OF THE DEPARTMENT OF HEALTH
ON THE
MORBIDITY AND MORTALITY
IN THE STATE OF NEW YORK
FOR THE YEAR 1910
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1911

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from this page as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2846

CERTIFICATE OF DEATH

02792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 years 11mo. 14days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1152 Calhoun Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Allen Last Ball				4. DATE OF DEATH Month 3 Day 29 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1912		9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Raulin Ball				14. MOTHER'S MAIDEN NAME Lucy Ann Taliifero			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 230-09-3122		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 593X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremic Coma DUE TO (c) Glomerulonephritis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type, Deteriorated							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15 , 19 55 to 3/29 , 1960 that I last saw the deceased alive on 3/29 , 19 60 and that death occurred at 6:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 3/30/60							
ACTUAL SIGNATURE <i>[Signature]</i>		PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 3/30/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-60		22c. NAME OF CEMETERY OR CREMATORY mt auburn		22d. LOCATION (City, town, or county) (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS 348 N. Calhoun St		24a. REC'D BY REGISTRAR DATE APR 1 '60	
						24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO BE DETACHED BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Board of Health to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
063
2804
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02793

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AnneArundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 17 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Harold Harbor Crownsville			
f. STREET ADDRESS Rt-2, Box-516A				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Debra Middle Jean Last BEAULIEU				4. DATE OF DEATH Month March Day 8 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1960	
9. AGE (In years lost birthday) yrs. 17		10. IF UNDER 1 YEAR Months 17 Days 25		11. IF UNDER 24 HRS. Hours 17 Min. 25		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Joseph Renaud BEAULIEU				14. MOTHER'S MAIDEN NAME Dorothy Irene MINER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Hospital Records			
17. INFORMANT Address Hospital Records				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse atelectasis and probable Hyaline Membranes 762.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) — DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subarachnoid and subdural hemorrhages, diffuse				INTERVAL BETWEEN ONSET AND DEATH 17 1/2 hrs			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Mar. 7, 1960 , to Mar. 8, 1960 , that (I) (we) last saw the deceased alive on Mar. 8, 1960 , and that death occurred at 4:55P. M, from the causes and on the date stated above.			
22a. SIGNATURE James I. Hudson, Jr.				22b. DATE SIGNED 9 MAR 60			
22c. PHYSICIAN'S NAME (Type) James I. Hudson, Jr.				22d. ADDRESS River Club Estates, Edgewater, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3-11-60			
23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEMETERY				23d. LOCATION (City, town, or county) (State) ANNAPOLIS MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Lortz, Annapolis, Md.				25a. REC'D BY REGISTRAR MAR 14 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kline				26. REGISTRAR'S SIGNATURE			

2063284XVI

CERTIFICATE OF DEATH

286



[Faint, mostly illegible text on a form, likely containing personal and medical details.]

2847

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade				c. LENGTH OF STAY IN 1b 1 mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PATRICIA Middle A Last BEE				4. DATE OF DEATH Month March Day 27 Year 19 60			
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> N/A <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 Feb 60	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Bee				14. MOTHER'S MAIDEN NAME Travis Joan Goins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. -			
17. INFORMANT (Father) Robert Bee				Address Qtrs 7115-F Ft Geo G Meade			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unk							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from DOA 27 Mar 19 60 to 0950AM from the causes and on the date stated above. live on and pronounced dead and the death occurred at							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Joseph R Rrokous M.D. USA Hosp Ft Geo G Meade, Md 27 Mar 60							
PHYSICIAN'S NAME (Type) JOSEPH RROKOUS, Capt., M.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify)							
22b. DATE THEREOF March 31, 1960							
22c. NAME OF CEMETERY OR CREMATORY Mt Royal Cemetery							
22d. LOCATION (City, town, or county) (State) Pittsburgh Pennsylvania							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS De Witt Sandelcar, Laurel Md							
24a. REC'D BY REGISTRAR APR 4 60							
24b. REGISTRAR'S SIGNATURE William S. Harris							

<p>Item 18 Film 259 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3-24-60 ams</p> <p style="font-size: 2em; font-weight: bold;">2848</p> <p style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">02795 27</p>			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Anne Arundel MARYLAND</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Connecticut b. COUNTY Fairfield</p>	
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G Meade</p>		<p>c. LENGTH OF STAY IN 1b 45X-3</p>	
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USA HOSPITAL Ft Geo G Meade, Md.</p>		<p>d. STREET ADDRESS 22 Chestnut</p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>First MABEL Middle Last BERRY</p>		<p>4. DATE OF DEATH</p> <p>Month March Day 8 Year 19 60</p>	
<p>5. SEX Female</p>	<p>6. COLOR OR RACE Cau</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 18 March 1886</p>
<p>9. AGE (In years last birthday) 73 yrs.</p>		<p>10. IF UNDER 1 YEAR Months Days Hours</p>	<p>11. IF UNDER 24 HRS. Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Army)</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY NURSE-</p>	
<p>11. BIRTHPLACE (State or foreign country) Canada</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Unknown Ebenezer Berry</p>		<p>14. MOTHER'S MAIDEN NAME Unknown</p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes</p>		<p>16. SOCIAL SECURITY NO. WW I -</p>	
<p>INFORMANT Niece Address Mrs Audrey Thompson 22 Chestnut St Darien Conn</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure/ 490X DUE TO Lobar Pneumonia, left upper Lobe; Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) both lower lobes DUE TO (c)</p>			<p>INTERVAL BETWEEN ONSET AND DEATH 14 hours</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19</p>	<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	<p>20f. (City or town) (County) (State)</p>
<p>21. I certify that I attended the deceased from 6 Mar, 19 60, to 8 Mar, 19 60, that I last saw the deceased alive on 8 Mar, 19 60, and that death occurred at 1136 A from the causes and on the date stated above.</p>			
<p>ADDRESS (Street, city or town, state) USA Hosp Ft Geo G Meade, Md.</p>			
<p>DATE SIGNED 10 Mar 60</p>			
<p>ACTUAL SIGNATURE Nathaniel S Beard</p>		<p>PHYSICIAN'S NAME (Type) NATHANIEL S BEARD Jr Capt M.C.</p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>	<p>22b. DATE THEREOF 3-14-60</p>	<p>22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery</p>	<p>22d. LOCATION (City, town, or county) (State) Arlington, Virginia</p>
<p>23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street</p>		<p>24a. REC'D BY REGISTRAR DATE MAR 14 '60</p>	<p>24b. REGISTRAR'S SIGNATURE Arthur S. Kraus</p>

1

050

2

1

1

CERTIFICATE OF DEATH

2843

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2805

02796

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 43 Woodholme Road							
3. NAME OF DECEASED (Type or print) First Charles Middle BLYTHE Last BLYTHE				4. DATE OF DEATH Month March Day 17 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 14, 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber (ret.)				10b. KIND OF BUSINESS OR INDUSTRY self-emp.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles E. Blythe				14. MOTHER'S MAIDEN NAME Liza M. Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ////		17. INFORMANT Mrs. Helen Beall Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 591x Uremia + Congestive failure DUE TO (b) Subacute nephritis 4/4. DUE TO (c) Do Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes m. Pyoderma. foot legs							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-5-60 to Mar. 16, 1960 , that (I) (we) last saw the deceased alive on Mar. 16, 1960 , and that death occurred at 1:55A. M, from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley				22b. DATE SIGNED 1:55A.			
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 21 st. March '60		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE R. D. Singleton				ADDRESS Glen Burnie, Maryland		25a. REC'D BY REGISTRAR DATE MAR 22 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Knecht	



02306

02306

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
Last Name, First Name, Middle Name		Month, Day, Year		Male / Female	
Place of Birth		Date of Death		Cause of Death	
City, State, Country		Month, Day, Year		Disease, Injury, or Poison	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date		Date		Date	
Place		Place		Place	
City, State, Country		City, State, Country		City, State, Country	



2849

CERTIFICATE OF DEATH

02797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salesville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Salesville Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Chda</u> First <u>B.</u> Middle <u>Booze</u> Last		4. DATE OF DEATH Month <u>3-</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Booze</u>		14. MOTHER'S MAIDEN NAME <u>Martha Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no; or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Chester White</u> Address <u>Salesville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>59</u> , to <u>March 1</u> , 1960, that I last saw the deceased alive on <u>Feb 27</u> , 1960, and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Md</u> DATE SIGNED <u>3/2/60</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-4-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		22d. LOCATION (City, town, or county) (State) <u>Salesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u> ADDRESS <u>Clarna Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1954

STATE OF TEXAS

1954



CERTIFICATE OF DEATH

02799

Reg. Dist. No.

2850

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #410 Irene Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Linda First ANN Middle Burkindine Last				4. DATE OF DEATH MARCH 13 Month 13 Day 1960 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 20, 1948	
9. AGE (In years last birthday) 11 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Burkindine				14. MOTHER'S MAIDEN NAME Lula Mae Legg ETI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Child		17. INFORMANT George Burkindine		Address 410 Irene Dr. Glen Burnie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus DUE TO (c) Congenital MALFORMATION						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 12 yrs 11 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 60 , to 3/12 , 19 60 , that I last saw the deceased alive on 2/12 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 715 Cottage Rd. Glen Burnie, Md. DATE SIGNED 3/13/60							
ACTUAL SIGNATURE R.W. Prichard M.D.				PHYSICIAN'S NAME (Type) R.W. PRICHARD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16th March 60		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.T. Singleton				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR MAR 16 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the State Board of Health for burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2806

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02800

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY aa			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Severna Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CAROLY Louise		First Middle Last CAMERON		4. DATE OF DEATH Month March Day 1 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 5, 1909	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) N. Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist				10b. KIND OF BUSINESS OR INDUSTRY Artist		11. BIRTHPLACE (State or foreign country) N. Y.	
13. FATHER'S NAME Malcolm John Cameron				14. MOTHER'S MAIDEN NAME Rakolyn A. Law			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 1018 St George Rd		17. INFORMANT Eleanor Case Balto. 10 Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal Failure 008X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 13, 1960 to Mar. 1, 1960 , that (I) (we) last saw the deceased alive on Mar. 1, 1960 , and that death occurred at 12:50P from the causes and on the date stated above.							
22a. SIGNATURE Edwin Davis, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/1/60	
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr.				22d. ADDRESS 98 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-2-1960		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemt		23d. LOCATION (City, town, or county) (State) Pri George Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Suro				ADDRESS Annapolis Md		25a. REC'D BY REGISTRAR DATE MAR 3 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

220

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 382A Route 5 Magothy Beach</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cheryl Carmean</u>				4. DATE OF DEATH Month Day Year <u>March 6th 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/53</u>		9. AGE (In years last birthday) <u>7</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Burton Carmean</u>				14. MOTHER'S MAIDEN NAME <u>Lorette Levesque</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary Infection</u> 085.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Measles</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Few days</u> <u>6 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/7/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10 Mar., 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Hyacinth</u>		22d. LOCATION (City, town, or county) (State) <u>Westbrook, Maine</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley, Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1997

2853

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 11mo. 1 year 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Estelle Middle Coleman Last Coleman				4. DATE OF DEATH Month 3 Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 28, 1883	
9. AGE (In years lost birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 214-07-9547		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Disease Associated with Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Central Nervous System Syphilis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Hot while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 4/22 , 19 58 , to 3/28 , 19 60 , that I last saw the deceased alive on 3/28 , 19 60 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 3/28/60							
ACTUAL SIGNATURE Hildegard Heard Reissman				PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Cedar Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. A. Wilson				ADDRESS 1000 Brantley Ave.		24a. REC'D BY REGISTRAR DATE APR 12 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached and placed in the burial-transit permit. Then please remove carbon paper and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1930

CERTIFICATE OF DEATH

3823



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

Approximate text visible (mostly illegible):

- Name: [illegible]
- Date: [illegible]
- Location: [illegible]
- Signature: [illegible]
- Witness: [illegible]
- Registrar: [illegible]

2854

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>A 17</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DEALE</i>				c. LENGTH OF STAY IN 1b <i>60 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X DEALE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>WILLIAM</i> Middle <i>COLLINS</i> Last <i>COLLINS</i>				4. DATE OF DEATH Month <i>MAR</i> Day <i>19</i> Year <i>1960</i>			
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAR 17, 1882</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WATERMAN</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Sea-food</i>		11. BIRTHPLACE (State or foreign country) <i>DEALE MD.</i>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>21716724</i>		17. INFORMANT Address <i>Linwood E. Collins Deale, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>years</i>						INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August, 1959</i> , to <i>March 19, 1960</i> , that I last saw the deceased alive on <i>March 19, 1960</i> , and that death occurred at <i>10:45 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.				ADDRESS (Street, city or town, state) <i>Shady Side</i>		DATE SIGNED <i>3/20/60</i>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar 22, 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. James</i>		22d. LOCATION (City, town, or county) (State) <i>Tracy's Landing Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard H. Harty</i>				ADDRESS <i>Yolville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 24 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frame</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2855

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Mayo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>N</u> Last <u>COLLISON</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>	11. IF UNDER 24 HRS. Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster Packer</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Michales, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas E. Collison</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cadle Collison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>48-32-3222</u>	
17. INFORMANT <u>Susan Edna Collison- Wife- Same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic cardiac vascular</u> (c) <u>degenerative hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>45</u> , to <u>Mar 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 25</u> , 19 <u>60</u> , and that death occurred at <u>8:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Amos Garrett Blvd. Annapolis, Md.</u> DATE SIGNED <u>March 27, 1960</u>			
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D.		PHYSICIAN'S NAME (Type) <u>S. Borssuck MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 29, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mayo, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

25

1.4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2856 CERTIFICATE OF DEATH

64091

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn			c. LENGTH OF STAY IN 1b 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Severn		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stevensons Road				d. STREET ADDRESS Stevensons Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank J. Colmus First Middle Last				4. DATE OF DEATH March 30 19 60 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 12, 1902	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Frank J. Colmus				14. MOTHER'S MAIDEN NAME Minnie Schultz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1919-1923				16. SOCIAL SECURITY NO. 215-09-4866		17. INFORMANT Mrs. Theresa Stone 315 Annapolis Blvd. G. B. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Tuberculosis. 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/6 19 59 , to 3/30 19 60 , that (I) (we) last saw the deceased alive on 3/29 19 60 , and that death occurred at 7 A. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Gustave H. Faubert</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 31, 1960	
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert M.D.				22d. ADDRESS 5 First Ave. S. E. Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 1, 1960		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond</i>				ADDRESS 4001 Ritchie Hwy. Balto. 25		25a. REC'D BY REGISTRAR DATE APR 5 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i>			

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health.

10001

CERTIFICATE OF DEATH

3225



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02805

2807

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dlaire Middle Hale Last DARBY				4. DATE OF DEATH Month March Day 25 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. 3		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Russell DARBY				14. MOTHER'S MAIDEN NAME Jeannie Ross Purdie RAMSAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Mar. 22, 1960 to Mar. 25, 1960 , that (I) (we) last saw the deceased alive on Mar. 25, 1960 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE Niel H. Sims				22b. DATE SIGNED 10:30 A.		22c. PHYSICIAN'S NAME (Type) Niel H. Sims	
22d. ADDRESS 95 Cathedral St., Annapolis, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/60		23c. NAME OF CEMETERY OR CREMATORY Woodfield		23d. LOCATION (City, town, or county) _____ (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard O. Heddy				25a. REC'D BY REGISTRAR DATE MAR 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

063

I

0

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

2807



MAINTAINED AT DEPARTMENT OF HEALTH
JANUARY 1907

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF WITNESSES: [illegible]
OFFICIAL USE: [illegible]

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health for use in burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2857
CERTIFICATE OF DEATH

02806

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 E. Maple Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> d. STREET ADDRESS <u>500 E. Maple Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PHILIP</u> Middle <u>H.</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 5, 1872</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hardwood Floors & Stairs</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u> </u>							
13. FATHER'S NAME <u>Edward Davis</u>				14. MOTHER'S MAIDEN NAME <u>Susann E. Kraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-8739A</u>		17. INFORMANT <u>Mrs. Selma M. Davis - 500 E. Maple Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC C-V. DIS.</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>15 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>May 1950</u> to <u>Mar. 31, 1960</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Mar. 18, 1960</u> , and that death occurred on <u>Mar. 31, 1960</u> at <u>6 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert Goldstone</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HERBERT GOLDSTONE M.D.</u>				22d. ADDRESS <u>1810 EUTAW PL. BALT. 17.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickner & Sons - Balt. 17</u>				25a. REC'D BY REGISTRAR DATE <u>APR 4 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

ep 1

02406

CERTIFICATE OF DEATH

2833



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02807

2808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MAINE b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RUMFORD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 91 SELLERS ROAD, ANNAPOLIS, MD.				d. STREET ADDRESS 82 MAIN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER First LEO Middle DYER Last				4. DATE OF DEATH Month MARCH Day 27 Year 1960			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 3-12-03		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY USN RETIRED		11. BIRTHPLACE (State or foreign country) MAINE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE J. DYER				14. MOTHER'S MAIDEN NAME ANNIE J. CAVANAUGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) YES WW II		16. SOCIAL SECURITY NO. None		17. INFORMANT Address 91 Sellers Road, Daughter Diane J. De Winter Annapolis, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (a), stating the underlying cause last. DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. Linhardt</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. LINHARDT				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3/27/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 31, 1960		22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i> ADDRESS Annapolis, Maryland				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Thorne</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. GENERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. A carbon copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02808

2841

CERTIFICATE OF DEATH

Items 3,4 FilmG260 4-4-60 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Severna Park</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Annapolis Road</u>				STREET ADDRESS (If rural give location) <u>Old Annapolis Road Box 216</u>			
3. NAME OF DECEASED (Type or Print) <u>Sarah Sarah E. Feeser</u>				4. DATE OF DEATH <u>March 25, 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 5, 1875</u>	
9. AGE last birthday <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Philip W. Bonebrake</u>		14. MOTHER'S MAIDEN NAME <u>Neville</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Harry F. Feeser (Son)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April, 1959</u> , to <u>March, 1960</u> , that I last saw the deceased alive on <u>25 March, 1960</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gene L. Trettin</u>				ADDRESS (Street, city, town, state) <u>M.D. 715 Cedar Rd., Glen Burnie Md</u>		DATE SIGNED <u>26 Mar 1960</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/28/60</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. Tully</u>		ADDRESS <u>Acc. md</u>	
DATE <u>MAR 29 '60</u>							

58-55

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. COUNTY		3. CITY		4. STATE	
5. DATE OF DEATH		6. TIME OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. SEX		10. AGE		11. RACE		12. RELIGION	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. SOCIAL STATUS	
17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS	
21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER	
29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER	
33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER	
41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER	
45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER	
53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER		56. PREVIOUS OTHER	
57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	
61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER	
65. PREVIOUS OTHER		66. PREVIOUS OTHER		67. PREVIOUS OTHER		68. PREVIOUS OTHER	
69. PREVIOUS OTHER		70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER	
73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER	
77. PREVIOUS OTHER		78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER	
81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER	
85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER	
89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER	
93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER	
97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER		100. PREVIOUS OTHER	

ENCLOSURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2809

CERTIFICATE OF DEATH

02809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912 WINDSOR AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>REBECCA</u> Last <u>FORD</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BULL</u>		14. MOTHER'S MAIDEN NAME <u>MARY TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>MRS. LILLIAN HENDRICKS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>10</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-12-1960</u> to <u>3-18-1960</u> , that I lost saw the deceased alive on <u>3-16-1960</u> , and that death occurred at <u>home</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis M Shipley</u>		DATE SIGNED <u>3-18-60</u>	
PHYSICIAN'S NAME (Type) <u>Francis M Shipley</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral St Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 21-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>			

1
Any still and living 2 years

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Reg. Dist. No.

1. NAME OF DECEASED MARIAM		2. SEX F	
3. AGE 24		4. DATE OF BIRTH 1914	
5. PLACE OF BIRTH BALTIMORE		6. OCCUPATION SEWING	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1914	
9. NAME OF SPOUSE JOHN		10. DATE OF DEATH 1914	
11. PLACE OF DEATH BALTIMORE		12. CAUSE OF DEATH DIPHTHERIA	
13. MEDICAL HISTORY DIPHTHERIA		14. HISTORY OF PRESENT ILLNESS DIPHTHERIA	
15. SIGNATURE OF PHYSICIAN J. H. HARRIS		16. SIGNATURE OF REGISTRAR J. H. HARRIS	
17. SIGNATURE OF DECEASED MARIAM		18. SIGNATURE OF WITNESSES J. H. HARRIS	
19. SIGNATURE OF DECEASED MARIAM		20. SIGNATURE OF WITNESSES J. H. HARRIS	
21. SIGNATURE OF DECEASED MARIAM		22. SIGNATURE OF WITNESSES J. H. HARRIS	
23. SIGNATURE OF DECEASED MARIAM		24. SIGNATURE OF WITNESSES J. H. HARRIS	
25. SIGNATURE OF DECEASED MARIAM		26. SIGNATURE OF WITNESSES J. H. HARRIS	
27. SIGNATURE OF DECEASED MARIAM		28. SIGNATURE OF WITNESSES J. H. HARRIS	
29. SIGNATURE OF DECEASED MARIAM		30. SIGNATURE OF WITNESSES J. H. HARRIS	
31. SIGNATURE OF DECEASED MARIAM		32. SIGNATURE OF WITNESSES J. H. HARRIS	
33. SIGNATURE OF DECEASED MARIAM		34. SIGNATURE OF WITNESSES J. H. HARRIS	
35. SIGNATURE OF DECEASED MARIAM		36. SIGNATURE OF WITNESSES J. H. HARRIS	
37. SIGNATURE OF DECEASED MARIAM		38. SIGNATURE OF WITNESSES J. H. HARRIS	
39. SIGNATURE OF DECEASED MARIAM		40. SIGNATURE OF WITNESSES J. H. HARRIS	
41. SIGNATURE OF DECEASED MARIAM		42. SIGNATURE OF WITNESSES J. H. HARRIS	
43. SIGNATURE OF DECEASED MARIAM		44. SIGNATURE OF WITNESSES J. H. HARRIS	
45. SIGNATURE OF DECEASED MARIAM		46. SIGNATURE OF WITNESSES J. H. HARRIS	
47. SIGNATURE OF DECEASED MARIAM		48. SIGNATURE OF WITNESSES J. H. HARRIS	
49. SIGNATURE OF DECEASED MARIAM		50. SIGNATURE OF WITNESSES J. H. HARRIS	
51. SIGNATURE OF DECEASED MARIAM		52. SIGNATURE OF WITNESSES J. H. HARRIS	
53. SIGNATURE OF DECEASED MARIAM		54. SIGNATURE OF WITNESSES J. H. HARRIS	
55. SIGNATURE OF DECEASED MARIAM		56. SIGNATURE OF WITNESSES J. H. HARRIS	
57. SIGNATURE OF DECEASED MARIAM		58. SIGNATURE OF WITNESSES J. H. HARRIS	
59. SIGNATURE OF DECEASED MARIAM		60. SIGNATURE OF WITNESSES J. H. HARRIS	
61. SIGNATURE OF DECEASED MARIAM		62. SIGNATURE OF WITNESSES J. H. HARRIS	
63. SIGNATURE OF DECEASED MARIAM		64. SIGNATURE OF WITNESSES J. H. HARRIS	
65. SIGNATURE OF DECEASED MARIAM		66. SIGNATURE OF WITNESSES J. H. HARRIS	
67. SIGNATURE OF DECEASED MARIAM		68. SIGNATURE OF WITNESSES J. H. HARRIS	
69. SIGNATURE OF DECEASED MARIAM		70. SIGNATURE OF WITNESSES J. H. HARRIS	
71. SIGNATURE OF DECEASED MARIAM		72. SIGNATURE OF WITNESSES J. H. HARRIS	
73. SIGNATURE OF DECEASED MARIAM		74. SIGNATURE OF WITNESSES J. H. HARRIS	
75. SIGNATURE OF DECEASED MARIAM		76. SIGNATURE OF WITNESSES J. H. HARRIS	
77. SIGNATURE OF DECEASED MARIAM		78. SIGNATURE OF WITNESSES J. H. HARRIS	
79. SIGNATURE OF DECEASED MARIAM		80. SIGNATURE OF WITNESSES J. H. HARRIS	
81. SIGNATURE OF DECEASED MARIAM		82. SIGNATURE OF WITNESSES J. H. HARRIS	
83. SIGNATURE OF DECEASED MARIAM		84. SIGNATURE OF WITNESSES J. H. HARRIS	
85. SIGNATURE OF DECEASED MARIAM		86. SIGNATURE OF WITNESSES J. H. HARRIS	
87. SIGNATURE OF DECEASED MARIAM		88. SIGNATURE OF WITNESSES J. H. HARRIS	
89. SIGNATURE OF DECEASED MARIAM		90. SIGNATURE OF WITNESSES J. H. HARRIS	
91. SIGNATURE OF DECEASED MARIAM		92. SIGNATURE OF WITNESSES J. H. HARRIS	
93. SIGNATURE OF DECEASED MARIAM		94. SIGNATURE OF WITNESSES J. H. HARRIS	
95. SIGNATURE OF DECEASED MARIAM		96. SIGNATURE OF WITNESSES J. H. HARRIS	
97. SIGNATURE OF DECEASED MARIAM		98. SIGNATURE OF WITNESSES J. H. HARRIS	
99. SIGNATURE OF DECEASED MARIAM		100. SIGNATURE OF WITNESSES J. H. HARRIS	

2858

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY <u>Atlantic</u> <u>Cumberland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u> <u>Seabrook</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		d. STREET ADDRESS <u>Washington Avenue #37 Center Farm</u>	
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>MARIE</u> Last <u>FRANCO</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 March 1960</u>
9. AGE (In years lost birthday) yrs. <u>761.5</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Felix S. Franco</u>		14. MOTHER'S MAIDEN NAME <u>Gladys Swing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>N/A</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Placental Separation</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>21 March</u> , 19 <u>60</u> , to <u>21 March</u> , 19 <u>60</u> that I last saw the deceased alive on <u>21 March</u> , 19 <u>60</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>22 Mar 60</u>			
ACTUAL SIGNATURE <u>Roger C. Moyer</u> M.D. _____			
PHYSICIAN'S NAME (Type) <u>ROGER C. MOYER, CAPT., MC</u> <u>US Army Hospital, Fort Geo G Meade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-24-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

1931

CERTIFICATE OF DEATH

1931



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard death certificate form with fields for name, date of birth, date of death, cause of death, and place of death.]

NAME: _____

DATE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

SIGNATURE: _____

DATE: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2859

CERTIFICATE OF DEATH

02811

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANN ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANN ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>				c. LENGTH OF STAY IN 1b <u>12 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>417 B+A Blvd Glen Burnie</u>				e. STREET ADDRESS <u>1417 B+A Blvd Glen Burnie</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Charles</u> Last <u>George Jr</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19 1917</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Charles George Sr</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Koenig</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-03-3644</u>		17. INFORMANT <u>Edith I. George</u> Address <u>Glen Burnie Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY Arteriosclerosis</u> (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/2</u> <u>1958</u> , to <u>2/28</u> <u>1960</u> , that I last saw the deceased alive on <u>2/28</u> <u>1960</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Prichard</u> M.D.				DATE SIGNED <u>3/2/60</u>			
PHYSICIAN'S NAME (Type) <u>R. W. PRICHARD</u>				ADDRESS <u>715 Cottage Rd Glen Burnie Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>5 March 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Drington</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Knorr</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>MAR 4 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Anne Arundell MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Stea Burnie, Md LENGTH OF STAY (in this place) 3 days
 TOWN Stea Burnie, Md
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 522 Newfield Rd S.W.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore
 TOWN Baltimore
 STREET ADDRESS (If rural give location) 1531 Corrington, St

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ELIZABETH(no)GILLIGAN

4. DATE OF DEATH:

(Month)

(Day)

(Year)

March31960

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FWWid.7 April 18738611 mo.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

HousewifeHomeBaltimore, Md.Yes - USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

nononeSon - Edward Gilligan, 522 Newfield Rd.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

acute cardiac failure

Interval Between Onset And Death

1 day

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(b)

Arteriosclerotic Heart Disease - advanced age10 yrs

DUE TO

(c)

Renal Disease - incontinence1 yr.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Fracture RT. femur - nailed.3 mo.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

27 Dec 1959same as #11Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

None22. I hereby certify that I attended the deceased from 13 Dec, 1959, to 3 March, 1960, that I last saw the deceasedalive on 3 March, 1960, and that death occurred at 7:27 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.F. Namuzah M.D.901 Edgely Rd, Stea Burnie, Md.7 March 1960

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

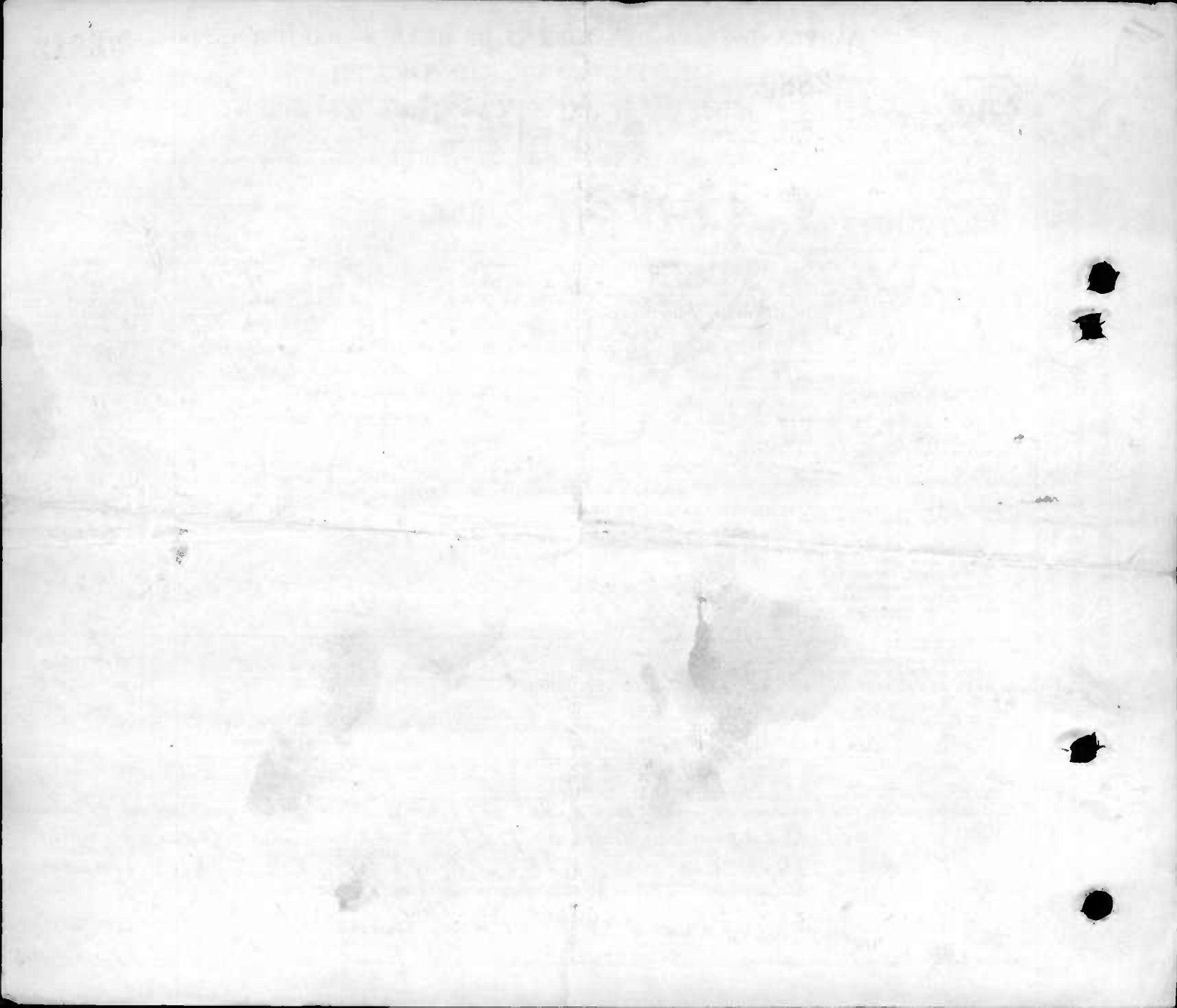
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7 MAR 7 '603-7-60Baltimore CemeteryBaltimore, Md.McCully Funeral Homes - 1305 Foothills

MARGIN RESERVED FOR BINDING



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02813

Item 7 Film G261 4/26/60 iwk

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY 2861 Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b 37 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) # 37 Reese Road			d. STREET ADDRESS Reese Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Leonard Glodek			4. DATE OF DEATH Month March Day 28th Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Oct. 1905		9. AGE (In yrs last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Mixer(ret)		10b. KIND OF BUSINESS OR INDUSTRY Pemco. Corp.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Glodek, Sr.			14. MOTHER'S MAIDEN NAME Magdaline Sij		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2 216-09-2339		17. INFORMANT Address Raymond Glodek-104 E. 3rd. Av. Ferndale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Silicosis 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Plus 5 y.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 April 1960		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
22d. LOCATION (City, town, or county) (State) Bklyn. R.F.D. Maryland		24a. REC'D BY REGISTRAR DATE APR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Richard V. Singleton Glen Burnie, Md.					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, for or to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



NEW YORK



MARYLAND STATE DEPARTMENT OF HEALTH - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

2862 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lambert's Md.</u>		c. LENGTH OF STAY IN 1b <u>3 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>California Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCES DOROTHEA GRAHAM</u>		4. DATE OF DEATH <u>Mar 26</u> 19 <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29</u> 19 <u>74</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Schaeffer</u>		14. MOTHER'S MAIDEN NAME <u>Spiesch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (List no. or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Earl L. Graham</u>		Address <u>349 Springdale Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio-sclerosis</u> DUE TO (c) <u>10 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 23</u> 19 <u>60</u> , to <u>Mar 26</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 25</u> 19 <u>60</u> , and that death occurred at <u>6:58 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmund G. Thewitt</u> M.D.		ADDRESS (Street, city or town, state) <u>Lambert's Md</u> DATE SIGNED <u>3-26-60</u>	
PHYSICIAN'S NAME (Type) <u>John F. Weibel</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar 29-1960</u>	<u>Landon Park</u>	<u>Balto Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Weibel</u> ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2810 CERTIFICATE OF DEATH

02815

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 94 Sellers Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle WILLIAM Last Graham		4. DATE OF DEATH Month March Day 11 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31 - 1894	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6 Days 11 Hours 11 Min.	IF UNDER 24 HRS. Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect Md. Racing Comm. Sect.		10b. KIND OF BUSINESS OR INDUSTRY Sect.		11. BIRTH PLACE (State or foreign country) Annapolis Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME HENRY C. GRAHAM				14. MOTHER'S MAIDEN NAME MARY M. KEELY N			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give no. or dates of service) W.W.I		17. INFORMANT MRS. H. WARREN MCCANN Address #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of sigmoid Colon DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1958 to 3-11-1960 that (I) (we) last saw the deceased alive on 3-11-1960 , and that death occurred at SH from the causes and on the date stated above.							
22a. SIGNATURE James R. Martin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-12-60	
22c. PHYSICIAN'S NAME (Type) Dr. James R. Martin				22d. ADDRESS Shaw St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 14-1960		23c. NAME OF CEMETERY OR CREMATORY St Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				25a. REC'D BY REGISTRAR DATE MAR 15 '60		25b. REGISTRAR'S SIGNATURE Orlando S. Hume	

063

1

0

1

063

1931

CERTIFICATE OF DEATH

1931

State of New York
County of New York
City of New York
I, the undersigned, being a duly qualified medical officer of health for the City and County of New York, do hereby certify that
the within and foregoing is a true and correct copy of the original record of death as the same appears from the files of the Department of Health of the City and County of New York.
Witness my hand and the seal of the Department of Health of the City and County of New York, this _____ day of _____, 1931.

Medical Officer of Health
Department of Health
City and County of New York

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 2863 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Annapolis</u> c. LENGTH OF STAY IN life <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 4 Box 33 Browns Woods</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>Green</u> Last <u></u>		4. DATE OF DEATH Month <u>March</u> Day <u>14th.</u> Year <u>19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/23/59</u>
9. AGE (In years last birthday) <u>3</u> yrs. <u>9</u> Months <u>0</u> Days <u></u> Hours <u></u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Floyd Green</u>		14. MOTHER'S MAIDEN NAME <u>Beulah Stansbury</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Beulah Stansbury (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Infection</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/14/60</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>		22d. LOCATION (City, town, or county) (State) <u>St. Margaret Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The funeral director should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2039161XV5

MAYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 100-100

NAME OF DECEASED LAST, FIRST, MIDDLE (If deceased was a child, give name of mother)		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
AGE Years _____ Months _____ Days _____		RACE White <input type="checkbox"/> Negro <input type="checkbox"/> Other <input type="checkbox"/>	
PLACE OF BIRTH State _____ County _____		DATE OF DEATH Year _____ Month _____ Day _____	
TIME OF DEATH Hour _____ Minute _____		PLACE OF DEATH Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/>	
OCCUPATION _____		CAUSE OF DEATH (If known, give full description of disease or injury)	
MANNER OF DEATH Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Undetermined <input type="checkbox"/>		SIGNATURE OF MEDICAL EXAMINER _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF DECEASED _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF CLERK _____	
SIGNATURE OF JURY _____		SIGNATURE OF JUDGE _____	
SIGNATURE OF SHERIFF _____		SIGNATURE OF CORONER _____	
SIGNATURE OF DISTRICT ATTORNEY _____		SIGNATURE OF COUNTY CLERK _____	
SIGNATURE OF TOWNSHIP CLERK _____		SIGNATURE OF VILLAGE CLERK _____	
SIGNATURE OF CITY CLERK _____		SIGNATURE OF STATE CLERK _____	

MAYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Form 100-100

2864 CERTIFICATE OF DEATH

02817

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural, Pasadena, Md.</i>		c. LENGTH OF STAY IN 1b <i>24 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Long Point</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Paul</i> Middle <i>Calvert</i> Last <i>Griffin</i>		4. DATE OF DEATH Month <i>March</i> Day <i>20</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 14, 1898</i>
9. AGE (In years last birthday) <i>61 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Buyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>retail shoes</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Robert W. Griffin</i>		14. MOTHER'S MAIDEN NAME <i>Annie Simons</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes WWI 1918-19</i>		16. SOCIAL SECURITY NO. <i>213-01-0842</i>	
17. INFORMANT <i>Mr. Isabelle Griffin</i>		Address <i>Pasadena P.O. Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>190.9</i> DUE TO <i>Uremia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute coronary thrombosis</i> (c) <i>Malignant melanoma</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>2 months</i> <i>1-year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January 10, 1951</i> , to <i>March 20, 1960</i> , that I last saw the deceased alive on <i>March 19, 1960</i> , and that death occurred at <i>10:10 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		DATE SIGNED <i>Mar 20 1960</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		M.D. <i>R. F. O'S. Box 442 - Pasadena, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/23/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>A. A. Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Am. J. Tickner & Sons - Balto.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 24 '60</i>	
ADDRESS <i>Mid</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kistner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 14

1 1 M X I 0 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2865 CERTIFICATE OF DEATH

Reg. Dist. No.

02818

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. LENGTH OF STAY IN 1b 46 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 Hammonds Ferry Rd.		d. STREET ADDRESS 200 Hammonds Ferry Road	
3. NAME OF DECEASED (Type or print) Charles		4. DATE OF DEATH Month March Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1881
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom Supply		10b. KIND OF BUSINESS OR INDUSTRY Self empolyed	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hare		14. MOTHER'S MAIDEN NAME Mary Bloom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-34-1600	
17. INFORMANT Charles T. Hare		1124 Armistead Arundel Hills Glen Burnie	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19, 1960 to March 20, 1960 , that I last saw the deceased alive on March 20, 1960 , and that death occurred at 10:20 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Florian P. Nadolski		ADDRESS (Street, city or town, state) 2103 Hammonds Ferry Rd Baltimore 24, Md	
PHYSICIAN'S NAME (Type) Florian P. Nadolski M.D.		DATE SIGNED 3/22/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 23 March 1960	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard T. Lingle		24a. REC'D BY REGISTRAR Mar 28 '60	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Gillian S. Hare	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
SIGNS AND SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
PATHOLOGICAL FINDINGS		LABORATORY TESTS	
POST-MORTEM FINDINGS		OTHER FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

RECEIVED
BALTIMORE
MAY 10 1910
STATE DEPARTMENT OF HEALTH
BALTIMORE, MD

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from page 1 and 2 should be filed with the State Board of Health for burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2811
CERTIFICATE OF DEATH

02819

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle HAWKINS Last HAWKINS				4. DATE OF DEATH Month March Day 20 Year 19 60			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1896	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ward				10b. KIND OF BUSINESS OR INDUSTRY Private family			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George Allen				14. MOTHER'S MAIDEN NAME Mary Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-30-5931A			
17. INFORMANT Mary Hoste				Address 162 Obery Ct.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Extensive Carcinoma of Cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) body of uterus DUE TO (c) 19 mos.				INTERVAL BETWEEN ONSET AND DEATH 19 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/11/58 to 3/20/60 , that (I) (we) lost the deceased on Mar. 20, 1960 , and that death occurred at 3:00P. M, from the causes and on the date stated above.				22a. SIGNATURE R. L. Richardson			
22b. PHYSICIAN'S NAME (Type) R. L. Richardson				22c. ADDRESS 110 Clay St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-24-1960			
23c. NAME OF CEMETERY OR CREMATORY Brewer Hall				23d. LOCATION (City, town, or county) (State) Annapolis Md.			
24. FUNERAL DIRECTOR'S SIGNATURE William R. Ruse				25. REC'D BY REGISTRAR MAR 23 '60			
25. REGISTRAR'S SIGNATURE Arthur S. Hanna				26. REGISTRAR'S SIGNATURE Arthur S. Hanna			

1983

DEPARTMENT OF HEALTH
STATE OF NEW YORK

CERTIFICATE OF DEATH

1983

DATE OF DEATH: 10/10/83

DECEASED

REPORTED BY

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

MADE IN U.S.A.
COPYRIGHT 1983
MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, please detach at the line marked "F" and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2812 CERTIFICATE OF DEATH

02820

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital		d. STREET ADDRESS 10 Bunche St.	
3. NAME OF DECEASED (Type or print) First Thomas Middle A. Last HAWKINS		4. DATE OF DEATH Month March Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1914
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Alt. Naval Cadet		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas Hawkins	
14. MOTHER'S MAIDEN NAME Agnes Allen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 100-1-100000		17. INFORMANT Mary Hastel / Zobery Channa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema of lungs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1958 to March 23, 1960 , that (I) (we) last saw the deceased alive on 3/12/60 , and that death occurred at 8:15 A.M. M, from the causes and on the date stated above.			
22a. SIGNATURE R. L. Richardson		22b. DATE SIGNED 3/23/60	
22c. PHYSICIAN'S NAME (Type) R. L. Richardson		22d. ADDRESS 110 Clay St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-25-1960	
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town, or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Keese		25a. REC'D BY REGISTRAR William S. Thomas	
ADDRESS Annapolis Md.		25b. REGISTRAR'S SIGNATURE William S. Thomas	
DATE MAR 24 '60			

5.

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2813

CERTIFICATE OF DEATH

Reg. Dist. No.

02821

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>532 Burnside St</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Emma</i> Middle <i>P.</i> Last <i>Heinemann</i>				4. DATE OF DEATH Month <i>Mar.</i> Day <i>25</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Mar 31 1867</i>	
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Peter Fred Peters</i>				14. MOTHER'S MAIDEN NAME <i>Lena Fischer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>James R. Wilson</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1 Arteriosclerotic Cardiovascular Disease</i> DUE TO <i>Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO <i></i> (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Jan 1955</i> , 19... to <i>Jan 25 1960</i> , that I last saw the deceased alive on <i>MAR 25 1960</i> , 19... and that death occurred at <i>8 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edwin L. H. H. H.</i>				M.D. <i>Chas. F. H. H. H.</i> ADDRESS (Street, city or town, state) <i>Annapolis Md</i> DATE SIGNED <i>4/1/60</i>			
PHYSICIAN'S NAME (Type) <i>E. L. H. H. H.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar 28-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i> ADDRESS <i>Sims Annapolis Md</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100000

4-10-1918

CERTIFICATE OF DEATH

2813

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
JAMES H. HARRIS		Male		35		1883	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
Baltimore, Md.		Carpenter		Heart Disease		Home	
9. DATE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
April 10, 1918		10:30 AM		J. H. Harris		J. H. Harris	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY		15. NAME OF MINISTER		16. NAME OF FUNERAL HOME	
Baltimore, Md.		Greenwood Cemetery		Rev. J. H. Harris		J. H. Harris	
17. NAME OF NEXT OF KIN		18. NAME OF WITNESS		19. NAME OF WITNESS		20. NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

100000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02822

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theodore Middle HIBBERD Last HIBBERD				4. DATE OF DEATH Month March Day 28 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1906	9. AGE (In years last birthday) 54 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		11. BIRTHPLACE (State or foreign country) Kansas
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Sherwood Press		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles Hibberd				14. MOTHER'S MAIDEN NAME Alice M Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Marie M Hibberd Edgewater Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 DUE TO Azotemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestinal obstruction (small bowel) DUE TO (c) 4 days INTERVAL BETWEEN ONSET AND DEATH 4 days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 25, 1960 to Mar. 28, 1960 , that (I) (we) last saw the deceased alive on Mar. 28, 1960 , and that death occurred at 8:00P. M, from the causes and on the date stated above.							
22a. SIGNATURE James R. Martin				22b. DATE SIGNED 3/29/60		22c. PHYSICIAN'S NAME (Type) James R. Martin	
22d. ADDRESS 6 Shaw St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/60		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland.				25a. REC'D BY REGISTRAR DATE APR 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO BE RETAINED BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the funeral director should be detached from the State Board of Health and the State Board of Health should be filed with the State Board of Health.

063

1

2

1

BP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2815 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02823

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNE ARUNDEL - MD</u> c. LENGTH OF STAY IN 1b <u>Baltimore</u> 03X-2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2 Best Avenue.</u>	
3. NAME OF DECEASED (Type or print) <u>JACK</u> First <u>J.</u> Middle <u>H</u> Last <u>LISTA</u> 4. DATE OF DEATH Month <u>MAR.</u> Day <u>20</u> Year <u>1960</u>		5. SEX <u>M.</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>10-30-54</u> 9. AGE (In years last birthday) <u>5</u> yrs. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>Balto.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u> 14. MOTHER'S MAIDEN NAME <u>Agnes Walker</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mr. William A. Harvey</u> Address <u>Best Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral fracture skull</u> <u>861x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Reenbox Rt. Cheek</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>35 min 5</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>Carplane Crash</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Carplane Crash</u>	
20c. TIME OF INJURY Month, Day, Year <u>3/20 1960</u> Hour <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>Highway</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> 20f. (City or town) <u>AAAG MD</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. H. H. H.</u> EXAMINER'S NAME (Type) <u>E. L. H. H. H.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-20-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>3-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Albans</u> 22d. LOCATION (City, town, or county) <u>Randallstown, Md</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>8738 Liberty Rd</u> <u>Randallstown, Md.</u>		24a. RECEIVED BY REGISTRAR <u>MAR 23 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, for burial, cremation, or removal, and in any event within 72 hours after death.

02883

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
221 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

8

HOSPITAL

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

2816 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 King George Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First HELEN Middle P Last HOLDEN		4. DATE OF DEATH Month MARCH Day 11 Year 1960	
5. SEX Felame	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1983
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Sedlacek		14. MOTHER'S MAIDEN NAME Katie Hronek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs John R. Riley- Daughter-		Address Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Complicated Heart Failure, Hemiparesis Chorea			INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 10, 1960 to March 11, 1960 , that I last saw the deceased alive on March 10, 1960 , and that death occurred at 6:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 31 Southgate Ave., Annapolis, Maryland DATE SIGNED March 11, 1960			
ACTUAL SIGNATURE Maurice F. Klawans M.D.		PHYSICIAN'S NAME (Type) Maurice F. Klawans MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1960	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR MAR 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krawns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

... 2

2866 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 11 years 8 mo. 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Hooper Last Hooper				4. DATE OF DEATH Month 3 Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1898?	
9. AGE (In years last birthday) 62?		10. IF UNDER 1 YEAR Months 3 Days 15 Hours 19 Min. 60		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilis of the Central Nervous System, Chronic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour 9 m. - p. m. - 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/14 , 19 48 to 3/15 , 19 60 , that I last saw the deceased alive on 3/15 , 19 60 , and that death occurred at 11:48 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.			
DATE SIGNED 3/16/60							
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				Crownsville State Hospital, Md. 3/16/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-60		22c. NAME OF CEMETERY University Trce		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS [Address]			
24a. REC'D BY REGISTRAR DATE 3-17-60				24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2883 CENTINQUE DE DEATH

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

10/20/1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2867 CERTIFICATE OF DEATH

Reg. Dist. No.

02826

1. PLACE OF DEATH a. COUNTY MARYLAND Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b lmo. 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last (Edgar) Edward Lawrence Jackson				4. DATE OF DEATH Month Day Year 3 29 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 18, 1884	
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Jackson				14. MOTHER'S MAIDEN NAME Marie Edwards			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiomyopathy, Heart Disease DUE TO (c) Senility							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia Reaction Paranoic Type							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) -----				20f. (City or town) (County) (State) -----			
21. I certify that I attended the deceased from 2/21 , 19 33 , to 3/29 , 19 60 , that I last saw the deceased alive on 3/29 , 19 60 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.			
DATE SIGNED 3/29/60				DATE SIGNED 3/29/60			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				Crownsville State Hospital, Md. 3/29/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4/4/60			
22c. NAME OF CEMETERY OR CREMATORY BASIL CHAPEL				22d. LOCATION (City, town, or county) (State) BALTO. COUNTY MD.			
23. FUNERAL DIRECTOR'S SIGNATURE W. I. CHATMAN				ADDRESS -1701 M^cULLOH ST			
24a. REC'D BY REGISTRAR Apr 4 '60				24b. REGISTRAR'S SIGNATURE Charles J. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy.

CERTIFICATE OF DEATH

282

Dec. 15, 1984
Age 65
Male
White
Married
Social Security No. 123-45-6789
Place of Birth: New York, N.Y.
Usual Residence: 123 Main St., New York, N.Y.
Cause of Death: Heart Disease
Immediate Cause: Myocardial Infarction
Underlying Cause: Coronary Atherosclerosis
Contributing Cause: Hypertension
Manner of Death: Natural
Physician's Signature: [Signature]
Date: Dec. 15, 1984
Place of Death: Home
Attending Physician: Dr. John Doe
Medical Examiner: Dr. Jane Smith
Hospital Name: St. Mary's Hospital
City: New York, N.Y.
County: New York
State: New York

Dec. 15, 1984
Age 65
Male
White
Married
Social Security No. 123-45-6789
Place of Birth: New York, N.Y.
Usual Residence: 123 Main St., New York, N.Y.
Cause of Death: Heart Disease
Immediate Cause: Myocardial Infarction
Underlying Cause: Coronary Atherosclerosis
Contributing Cause: Hypertension
Manner of Death: Natural
Physician's Signature: [Signature]
Date: Dec. 15, 1984
Place of Death: Home
Attending Physician: Dr. John Doe
Medical Examiner: Dr. Jane Smith
Hospital Name: St. Mary's Hospital
City: New York, N.Y.
County: New York
State: New York

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE-ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margaret</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pleasant Plains Farm</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GERTIE</u> Middle <u>-</u> Last <u>JOHNSON</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5th</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? JAN. 1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>? AA Co, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN - FORD</u>				14. MOTHER'S MAIDEN NAME <u>? MARGARET ROSS ROGERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Esther W. Singleton (daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annabel's Maternal Cmt.</u>	
22d. LOCATION (City, town, or county) <u>Annabel, Md.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1 063 1 0 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 063 1 0 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2817 CERTIFICATE OF DEATH

02828

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel L.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>A-A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp</u>		d. STREET ADDRESS <u>113 Cleveland Beach Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Harland Johnson</u>		4. DATE OF DEATH <u>March 12 1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 23 1921</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Force</u>	11. BIRTHPLACE (State or foreign country) <u>Yamstown N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Gusta A. Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Daisy Thompson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>	
16. SOCIAL SECURITY NO. <u>581.0</u>		17. INFORMANT <u>Mother Mrs Johnson</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO <u>Pneumonia</u> DUE TO <u>Cerebrovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1959</u> , 19 <u>60</u> , to <u>1960</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-11-60</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park 3-12-60</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		DATE SIGNED <u>3-12-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Busti, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		24. REGISTRY REGISTAR <u>Arthur S. Hahn</u>	
24a. DATE <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hahn</u>	

CERTIFICATE OF DEATH

For use by

1. Name of deceased: JOHN J. SMITH 2. Sex: Male 3. Date of birth: 1910-01-15

4. Race: White

5. Usual residence: 1234 Main St., Baltimore, Md.

6. Date of death: 1960-03-10

7. Place of death: Home

8. Cause of death: Heart Disease

9. Manner of death: Natural

10. Signature of physician: Dr. J. H. Jones

11. Signature of registrar: John Doe

12. Signature of informant: John Doe

13. Signature of funeral director: John Doe

14. Signature of coroner: John Doe

15. Signature of medical examiner: John Doe

16. Signature of health officer: John Doe

17. Signature of state health officer: John Doe

18. Signature of state health officer: John Doe

19. Signature of state health officer: John Doe

20. Signature of state health officer: John Doe

21. Signature of state health officer: John Doe

22. Signature of state health officer: John Doe

23. Signature of state health officer: John Doe

24. Signature of state health officer: John Doe

25. Signature of state health officer: John Doe

26. Signature of state health officer: John Doe

27. Signature of state health officer: John Doe

28. Signature of state health officer: John Doe

29. Signature of state health officer: John Doe

30. Signature of state health officer: John Doe

31. Signature of state health officer: John Doe

32. Signature of state health officer: John Doe

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2869

CERTIFICATE OF DEATH

02829

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas, Md. (6 miles from Towson) 03X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Convalescent Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Winfield Middle Johnson Last Johnson		4. DATE OF DEATH Month March Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-1880
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 79 Days 24 Hours 19 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Amos Johnson	
14. MOTHER'S MAIDEN NAME Rachel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Plaza Manor Convalescent Home - Glen Burnie, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile mental deterioration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 304X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ? yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy- petit mal.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from August 1 , 19 58 , to March 24 , 19 60 , that I last saw the deceased alive on March 19 , 19 60 , and that death occurred at 9:15 A .M., from the causes and on the date stated above.		
ACTUAL SIGNATURE James M. Pair M.D. 400 N. Carrollton Avenue		DATE SIGNED 3-24-1960
PHYSICIAN'S NAME (Type) James M. Pair, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-24-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		24a. REC'D BY REGISTRAR MAR 29 '60
ADDRESS 802 Madison Ave., Balto., Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2870

CERTIFICATE OF DEATH

02830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle May Last Jones				4. DATE OF DEATH Month 3 Day 16 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1864 - Dec. 19th	
9. AGE (In years lost birthday) yrs. 95		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher?		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Generalized & Cerebral Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcer - Senility - Chronic Brain Syndrome Asso. with Cerebral Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. - p. m. - 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/13 , 19 52 , to 3/16 , 19 60 , that I last saw the deceased alive on 3/16 , 19 60 and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 3/17/60 ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. PHYSICIAN'S NAME (Type) Crownsville State Hospital, Md. 3/17/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/1960		22c. NAME OF CEMETERY OR CREMATORY Church		22d. LOCATION (City, town, or county) (State) Quantico Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clifton O. Stewart Salesbury				24a. RECEIVED BY REGISTRAR DATE MAR 23 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

02-24

2870 - CENTER ATCH OF DEATH

Woodstock

Married

Anne Arnold

Married

Age 25 days

Married

Married

Married

Married

Married

Married

1904 - Dec. 19th

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

1904 - Dec. 19th

1904 - Dec. 19th

1904 - Dec. 19th

Married

Married

Married

Married

Married

Married

Married

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2871

CERTIFICATE OF DEATH

02831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Convalescent Home		d. STREET ADDRESS 1602 McCulloh Street	
3. NAME OF DECEASED (Type or print) First James Middle Last Jones		4. DATE OF DEATH Month March Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 18, 1913
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dish Washer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Danville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-01-5380	
17. INFORMANT Mrs. Orandle-D.P.W. Balto. City.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from March 1, 1960 , to March 7, 1960 , that I last saw the deceased alive on March 5, 1960 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James M. Pair		ADDRESS (Street, city or town, state) 400 N. Carrollton Ave. Balto 23 Md.	
PHYSICIAN'S NAME (Type) James M. Pair, M.D.		DATE SIGNED 3-7-1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-9-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS 802 Madison Avenue		24a. REC'D BY REGISTRAR MAR 9 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
John Doe		1910-01-01		Male	
Place of Birth		Date of Death		Time of Death	
Baltimore, Maryland		1960-01-01		10:00 AM	
Cause of Death		Manner of Death		Occupation	
Heart Disease		Natural		Teacher	
Detailed Cause of Death		Detailed Manner of Death		Detailed Occupation	
Myocardial Infarction		Accidental		Public School Teacher	
Detailed Description of Death		Detailed Description of Death		Detailed Description of Death	
Deceased was found dead in his home.		Deceased was found dead in his home.		Deceased was found dead in his home.	
Physician's Signature		Physician's Name		Physician's Address	
[Signature]		John Doe, M.D.		123 Main St., Baltimore, MD.	
Date of Certificate		Physician's License No.		Physician's State	
1960-01-01		123456789		Maryland	
Registrar's Signature		Registrar's Name		Registrar's Address	
[Signature]		John Doe, Registrar		123 Main St., Baltimore, MD.	
Date of Registration		Registrar's License No.		Registrar's State	
1960-01-01		123456789		Maryland	

RECEIVED

1

2842 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McKinsey Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Severna Park</u>	
3. NAME OF DECEASED (Type or print) <u>Laura Ann. Kaehler</u>		4. DATE OF DEATH <u>3-1-60</u> 19 <u>79</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31/1879</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Balto County</u>
13. FATHER'S NAME <u>William Trocey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Derdes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daughter</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>153.9</u> DUE TO (b) <u>Malignancy of bowel.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Gen. metastatic disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1958</u> , 19 <u> </u> , to <u>1960</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2-29-60</u> 19 <u> </u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holm</u>		DATE SIGNED <u>3-1-60</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4 March 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ro. V. Singleton</u>		24a. REC'D BY REGISTRAR <u>Mar 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 100

DATE OF DEATH
1940

NAME OF DECEASED
JAMES H. HARRIS

AGE
68

SEX
Male

RACE
White

DATE OF BIRTH
1872

PLACE OF BIRTH
BALTIMORE, MD

RESIDENCE
1000 N. E. ST. BALTIMORE, MD

CAUSE OF DEATH
HEART DISEASE

IMMEDIATE CAUSE OF DEATH
CORONARY THROMBOSIS

PERMANENT CAUSE OF DEATH
HYPERTENSION

INTERESTING FACTS
None

DATE OF EXAMINATION
1940

PLACE OF EXAMINATION
HOME

SIGNATURE OF PHYSICIAN
J. H. HARRIS

DATE OF SIGNATURE
1940

PLACE OF SIGNATURE
BALTIMORE, MD

DATE OF DEATH
1940

PLACE OF DEATH
BALTIMORE, MD

DATE OF DEATH
1940

2872

CERTIFICATE OF DEATH

02833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION South Down Shores				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LULA M.D. KELLENBENZ (also known as Lucinda Mary)				4. DATE OF DEATH Month Day Year March 3 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1897	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Douglas				14. MOTHER'S MAIDEN NAME Annie Amrhein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address John Elmer Kellenbenz-Husband- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gen. carcinomatosis due to 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) carcinoma of breast. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. , 1946, to Mar. 3 , 1960, that I last saw the deceased alive on March 2 , 1960, and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Amnapolis MD 375160							
ACTUAL SIGNATURE S. Borssuck		M.D. Amnapolis MD					
PHYSICIAN'S NAME (Type) S. Borssuck MD		Amos Garrett Blvd. Annapolis, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 7, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemeter.		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE MAR 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____
12. Place of registration: _____

2873

CERTIFICATE OF DEATH

1. NAME OF DECEASED
(Type or Print)

MR. Lena Mae King

2. DATE OF DEATH

3-20-1960

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)220 Homewood Rd.
Linthicum, Md.aa
County

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

A-A.

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

X Linthicum

D. STREET ADDRESS

(If rural, give location)

1220 Homewood Rd.

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

8-8-1886

9. AGE (In years
lost birthday)

73

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10. A. USUAL OCCUPATION (Give kind of
work done during most of working life, even
if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Hodges

14. MOTHER'S MAIDEN NAME

Vida —

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no.

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Son: Edward R. King

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary occlusion

5 minutes

ANTECEDENT CAUSES

420.1

(B) DUE TO

Hypertensive Cardiovascular disease years

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Cerebral vascular accident

6 months

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19a. DATE OF OPERATION

no

19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED

—

20. AUTOPSY?

YES ☐NO ☒

22. I certify that (I) (this hospital) attended the deceased from

3-24-

19.56 to

3-20-1960

that (I) (we) last saw the deceased alive on

3-20-

1960

and that in (my) (our) opinion death occurred at 5:40 P.m., from the causes and on the date stated above.

23a. SIGNATURE

Chas. Chas. Clinch M.D.

23b. ADDRESS

1 E. Randall St. Baltimore

23c. DATE SIGNED

3-20-60

24a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24b. DATE

3-23-60

24c. NAME OF CEMETERY OR CREMATORY

Mt. Harmony Cem.

24d. LOCATION

(City, town, or county)

Mt. Harmony, Md.

(State)

25a. DATE REC'D BY HEALTH DEPT.

MAR 24 1960

25b. NAME OF REGISTRAR

Arthur J. Hume

25c. FUNERAL DIRECTOR

McCully Funeral Homes 130 E. Fort Ave

ADDRESS

THIS IS A PERMANENT RECORD.

ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE OF DECEASED

SEX

COLOR

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
4
2813
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02835

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis d. STREET ADDRESS 846 West St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Royal Middle SMITH Last KIRBY		4. DATE OF DEATH Month March Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 5 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman		10b. KIND OF BUSINESS OR INDUSTRY Lumber Company	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Floyd Kirby		14. MOTHER'S MAIDEN NAME Sallie Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-24-8068	
17. INFORMANT Rosabelle Ada Kirby- Wife- Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 MAR 1960 to Mar. 16, 1960 , that (I) (we) last saw the deceased alive on Mar. 16, 1960 , and that death occurred at 8:20P. from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck M.D.		22b. DATE SIGNED 8:20P.	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 41 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 19, 1960	
23c. NAME OF CEMETERY OR CREMATORY All Hallows Cemetery		23d. LOCATION (City, town, or county) (State) Birdsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Maryland		25a. REC'D BY REGISTRAR MAR 21 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

MAINTAINED IN THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES
AND IN THE DEPARTMENT OF VETERANS AFFAIRS

NAME

DATE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

100-100000-1

X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2874 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02836

Reg. Dist. No.

1. PLACE OF DEATH Summer Residence a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01.4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 26		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bay Street, Venice				d. STREET ADDRESS 1601 Locust St. Curtis Bay			
3. NAME OF DECEASED (Type or print) First Middle Last Felix H. Kostkowski				4. DATE OF DEATH Month Day Year March 4th 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/18/95		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocery		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Kostkowski				14. MOTHER'S MAIDEN NAME Mary Batkowik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-32-8915		17. INFORMANT Address Mrs. Tillie Kostkowski (wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/4/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/60		22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS		22d. LOCATION (City, town, or county) (State) A.A. Co MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. S. Fialkowski</i>				ADDRESS 2007 Eastern Ave		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY		16. SIGNATURE OF WITNESSES	
17. HISTORY OF ILLNESS		18. PHYSICAL EXAMINATION		19. LABORATORY EXAMINATIONS		20. POST-MORTEM FINDINGS		21. TOXICOLOGICAL EXAMINATIONS		22. OTHER FINDINGS		23. COMMENTS		24. SIGNATURE OF JURY	
25. SIGNATURE OF EXAMINER		26. SIGNATURE OF ATTENDING PHYSICIAN		27. SIGNATURE OF CORONER		28. SIGNATURE OF JURY		29. SIGNATURE OF WITNESSES		30. SIGNATURE OF JURY		31. SIGNATURE OF WITNESSES		32. SIGNATURE OF JURY	

2875

CERTIFICATE OF DEATH

02837

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address, OR INSTITUTION) <u>319 Hammonds Ferry Rd.</u>		d. STREET ADDRESS <u>319 Hammonds Ferry</u>	
3. NAME OF DECEASED (Type or print) <u>Rose</u> First <u>ANNA</u> Middle <u>Machachlan</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/1877</u>
9. AGE (In years, last day) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sylvester Schuler</u>		14. MOTHER'S MAIDEN NAME <u>HANET MORRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Donald Machachlan Jr.</u>		Address <u>3195. Hammonds Ferry Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Loss of respiratory Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>2 hrs.</u> <u>1 m.o.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>-</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3/3</u>	20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>
21. I certify that I attended the deceased from <u>3/3</u> , 19 <u>60</u> , to <u>3/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Glen Burnie</u>		DATE SIGNED <u>3/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Glen Burnie, MD</u>		ADDRESS (Street, city or town, state) <u>715 Carter Rd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/19/60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Adelton Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCurdy - 130 E. Fort St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Glen B. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon 2, 3 and 4 and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. DIV. NO.

PLACE OF DEATH		MARRIAGE	
DATE OF DEATH		DATE OF MARRIAGE	
AGE OF DECEASED		AGE OF MARRIED	
SEX OF DECEASED		SEX OF MARRIED	
RACE OF DECEASED		RACE OF MARRIED	
EDUCATION OF DECEASED		EDUCATION OF MARRIED	
OCCUPATION OF DECEASED		OCCUPATION OF MARRIED	
RELIGION OF DECEASED		RELIGION OF MARRIED	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF MARRIED	
SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES	
SIGNATURE OF CLERK		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF SHERIFF		SIGNATURE OF SHERIFF	
SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF DISTRICT ATTORNEY	
SIGNATURE OF COUNTY CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF TOWNSHIP CLERK	
SIGNATURE OF VILLAGE CLERK		SIGNATURE OF VILLAGE CLERK	
SIGNATURE OF CITY CLERK		SIGNATURE OF CITY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF STATE CLERK	
SIGNATURE OF NATIONAL CLERK		SIGNATURE OF NATIONAL CLERK	
SIGNATURE OF INTERNATIONAL CLERK		SIGNATURE OF INTERNATIONAL CLERK	
SIGNATURE OF UNITED STATES CLERK		SIGNATURE OF UNITED STATES CLERK	
SIGNATURE OF FOREIGN CLERK		SIGNATURE OF FOREIGN CLERK	
SIGNATURE OF OTHER CLERK		SIGNATURE OF OTHER CLERK	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES	
SIGNATURE OF CLERK		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF SHERIFF		SIGNATURE OF SHERIFF	
SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF DISTRICT ATTORNEY	
SIGNATURE OF COUNTY CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF TOWNSHIP CLERK	
SIGNATURE OF VILLAGE CLERK		SIGNATURE OF VILLAGE CLERK	
SIGNATURE OF CITY CLERK		SIGNATURE OF CITY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF STATE CLERK	
SIGNATURE OF NATIONAL CLERK		SIGNATURE OF NATIONAL CLERK	
SIGNATURE OF INTERNATIONAL CLERK		SIGNATURE OF INTERNATIONAL CLERK	
SIGNATURE OF UNITED STATES CLERK		SIGNATURE OF UNITED STATES CLERK	
SIGNATURE OF FOREIGN CLERK		SIGNATURE OF FOREIGN CLERK	
SIGNATURE OF OTHER CLERK		SIGNATURE OF OTHER CLERK	

1

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

2876

CERTIFICATE OF DEATH

Reg. Dist. No.

02838

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>11mo. 8 years 1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Unknown</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Sylvester</u> Last <u>Madden</u>				4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 27, 1894</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Madden</u>				14. MOTHER'S MAIDEN NAME <u>Joanna Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>212-16-3962</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO <u>024X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Decubitus Ulcers</u> DUE TO (c) <u>Tabes Dorsalis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>				20f. (City or town) (County) (State) <u>-----</u>			
21. I certify that I attended the deceased from <u>4/16</u> , 19 <u>51</u> , to <u>3/27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>60</u> , and that death occurred at <u>5:32 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>3/28/60</u>							
ACTUAL SIGNATURE <u>Hildegard Heard</u>				M.D. <u>Crownsville State Hospital, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M.D.</u>				<u>Crownsville State Hospital, Md.</u> <u>3/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 31, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Lane & Sons</u>				ADDRESS <u>Reisterstown, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>3/28/60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

000000

CERTIFICATE OF DEATH

2000

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

02839

2819

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian		4. DATE OF DEATH Month March Day 18 Year 1960	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1894	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Housewife	
12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.	
14. FATHER'S NAME James Makell		15. MOTHER'S MAIDEN NAME Mary F. Davis	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 100-1-100000	
18. INFORMANT Daniel E. Makell, Cones Station		19. ADDRESS Cones Station	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Artery Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		21. INTERVAL BETWEEN ONSET AND DEATH 420.1	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23a. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		23b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
24a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24b. (City or town) (County) (State)	
25. I certify that (I) (this hospital) attended the deceased from Feb. 1959 to Mar. 17, 1960 , that (I) (we) last saw the deceased alive on Mar. 17, 1960 , and that death occurred at 6:55 A. M, from the causes and on the date stated above.		26. DATE SIGNED 3/18/60	
27a. SIGNATURE R. L. Richardson		27b. DATE SIGNED 3/18/60	
28c. PHYSICIAN'S NAME (Type) R. L. Richardson		28d. ADDRESS 110 Clay St., Annapolis, Md.	
29a. BURIAL, CREMATION, REMOVAL (Specify) Burial		29b. DATE THEREOF 3-22-1960	
29c. NAME OF CEMETERY OR CREMATORY Ebenezer		29d. LOCATION (City, town, or county) (State) Galesville Md.	
30. FUNERAL DIRECTOR'S SIGNATURE William Keese		31. ADDRESS Anna, Md.	
32a. REC'D BY REGISTRAR DATE MAR 21 '60		32b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

2818

NAME (Printed) _____
RESIDENCE _____
DATE OF BIRTH _____
PLACE OF BIRTH _____
OCCUPATION _____
CAUSE OF DEATH _____
MANNER OF DEATH _____
DATE OF DEATH _____
PLACE OF DEATH _____
SIGNATURE OF REGISTRAR _____
DATE _____

E. J. Registrar

2877

CERTIFICATE OF DEATH

02840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>2 Ridge Road, Glen Burnie</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>60 Glen Burnie (Marley Park)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Co</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GENEVIEVE</u> Middle <u>MC DEVITT</u> Last <u>MC DEVITT</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 Feb. 1901</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. (Cafeteria)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.C. Sch. Bd.</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>(unknown) Hersch</u>		14. MOTHER'S MAIDEN NAME <u>(unknown) Stevens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Margaret Doroz</u>		Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Asthmatic Attack</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial Asthma</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(Notation) Carried to South Baltimore Gen. Hospital, Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury and date of Part II of form) <u>DR. KIMES M.I. Authorized me to issue certificate on March 19, 60</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 26, 1960</u> , to <u>Jan. 27, 1960</u> , that I lost saw the deceased alive on <u>January 27, 1960</u> , and that death occurred at <u>11:00 P.M.</u> from the causes on the date stated above.			
ACTUAL SIGNATURE <u>Edmond I. Moushabek</u> M.D.		ADDRESS (Street, city or town, state) <u>2101 S. Ritchie Highway Md 19, 60</u>	
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK, Glen Burnie, Maryland</u>		DATE SIGNED <u>March 19, 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>22 March 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u> ADDRESS <u>Glen Burnie Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

327

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a formal certificate containing fields for name, date, and cause of death.]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2820 Items 12 & 16 Film G262 5/4/60 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CG</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>X Annapolis - MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. ANNE ARONDEL GENERAL.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WARNER</u> Middle <u>McFarland</u> Last <u>McFarland</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	9. AGE (In years last birthday) <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>166-18-9910</u>	
17. INFORMANT <u>AA General Hospital</u>		Address <u>Annapolis Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodside</u>
		22d. LOCATION (City, town, or county) <u>Lolesville Md.</u>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Baltimore Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. & Friend</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF DEATH [Faint text]		6. TIME OF DEATH [Faint text]	
7. PLACE OF DEATH [Faint text]		8. OCCASION OF DEATH [Faint text]	
9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF MEDICAL EXAMINER [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF NEXT OF KIN [Faint text]	
15. SIGNATURE OF CLERK [Faint text]		16. SIGNATURE OF JURY [Faint text]	
17. SIGNATURE OF JUDGE [Faint text]		18. SIGNATURE OF SHERIFF [Faint text]	
19. SIGNATURE OF CORONER [Faint text]		20. SIGNATURE OF DEPUTY CORONER [Faint text]	
21. SIGNATURE OF DEPUTY SHERIFF [Faint text]		22. SIGNATURE OF DEPUTY CLERK [Faint text]	
23. SIGNATURE OF DEPUTY JURY [Faint text]		24. SIGNATURE OF DEPUTY JUDGE [Faint text]	
25. SIGNATURE OF DEPUTY SHERIFF [Faint text]		26. SIGNATURE OF DEPUTY CORONER [Faint text]	
27. SIGNATURE OF DEPUTY CLERK [Faint text]		28. SIGNATURE OF DEPUTY JURY [Faint text]	
29. SIGNATURE OF DEPUTY JUDGE [Faint text]		30. SIGNATURE OF DEPUTY SHERIFF [Faint text]	
31. SIGNATURE OF DEPUTY CORONER [Faint text]		32. SIGNATURE OF DEPUTY CLERK [Faint text]	
33. SIGNATURE OF DEPUTY JURY [Faint text]		34. SIGNATURE OF DEPUTY JUDGE [Faint text]	
35. SIGNATURE OF DEPUTY SHERIFF [Faint text]		36. SIGNATURE OF DEPUTY CORONER [Faint text]	
37. SIGNATURE OF DEPUTY CLERK [Faint text]		38. SIGNATURE OF DEPUTY JURY [Faint text]	
39. SIGNATURE OF DEPUTY JUDGE [Faint text]		40. SIGNATURE OF DEPUTY SHERIFF [Faint text]	
41. SIGNATURE OF DEPUTY CORONER [Faint text]		42. SIGNATURE OF DEPUTY CLERK [Faint text]	
43. SIGNATURE OF DEPUTY JURY [Faint text]		44. SIGNATURE OF DEPUTY JUDGE [Faint text]	
45. SIGNATURE OF DEPUTY SHERIFF [Faint text]		46. SIGNATURE OF DEPUTY CORONER [Faint text]	
47. SIGNATURE OF DEPUTY CLERK [Faint text]		48. SIGNATURE OF DEPUTY JURY [Faint text]	
49. SIGNATURE OF DEPUTY JUDGE [Faint text]		50. SIGNATURE OF DEPUTY SHERIFF [Faint text]	
51. SIGNATURE OF DEPUTY CORONER [Faint text]		52. SIGNATURE OF DEPUTY CLERK [Faint text]	
53. SIGNATURE OF DEPUTY JURY [Faint text]		54. SIGNATURE OF DEPUTY JUDGE [Faint text]	
55. SIGNATURE OF DEPUTY SHERIFF [Faint text]		56. SIGNATURE OF DEPUTY CORONER [Faint text]	
57. SIGNATURE OF DEPUTY CLERK [Faint text]		58. SIGNATURE OF DEPUTY JURY [Faint text]	
59. SIGNATURE OF DEPUTY JUDGE [Faint text]		60. SIGNATURE OF DEPUTY SHERIFF [Faint text]	
61. SIGNATURE OF DEPUTY CORONER [Faint text]		62. SIGNATURE OF DEPUTY CLERK [Faint text]	
63. SIGNATURE OF DEPUTY JURY [Faint text]		64. SIGNATURE OF DEPUTY JUDGE [Faint text]	
65. SIGNATURE OF DEPUTY SHERIFF [Faint text]		66. SIGNATURE OF DEPUTY CORONER [Faint text]	
67. SIGNATURE OF DEPUTY CLERK [Faint text]		68. SIGNATURE OF DEPUTY JURY [Faint text]	
69. SIGNATURE OF DEPUTY JUDGE [Faint text]		70. SIGNATURE OF DEPUTY SHERIFF [Faint text]	
71. SIGNATURE OF DEPUTY CORONER [Faint text]		72. SIGNATURE OF DEPUTY CLERK [Faint text]	
73. SIGNATURE OF DEPUTY JURY [Faint text]		74. SIGNATURE OF DEPUTY JUDGE [Faint text]	
75. SIGNATURE OF DEPUTY SHERIFF [Faint text]		76. SIGNATURE OF DEPUTY CORONER [Faint text]	
77. SIGNATURE OF DEPUTY CLERK [Faint text]		78. SIGNATURE OF DEPUTY JURY [Faint text]	
79. SIGNATURE OF DEPUTY JUDGE [Faint text]		80. SIGNATURE OF DEPUTY SHERIFF [Faint text]	
81. SIGNATURE OF DEPUTY CORONER [Faint text]		82. SIGNATURE OF DEPUTY CLERK [Faint text]	
83. SIGNATURE OF DEPUTY JURY [Faint text]		84. SIGNATURE OF DEPUTY JUDGE [Faint text]	
85. SIGNATURE OF DEPUTY SHERIFF [Faint text]		86. SIGNATURE OF DEPUTY CORONER [Faint text]	
87. SIGNATURE OF DEPUTY CLERK [Faint text]		88. SIGNATURE OF DEPUTY JURY [Faint text]	
89. SIGNATURE OF DEPUTY JUDGE [Faint text]		90. SIGNATURE OF DEPUTY SHERIFF [Faint text]	
91. SIGNATURE OF DEPUTY CORONER [Faint text]		92. SIGNATURE OF DEPUTY CLERK [Faint text]	
93. SIGNATURE OF DEPUTY JURY [Faint text]		94. SIGNATURE OF DEPUTY JUDGE [Faint text]	
95. SIGNATURE OF DEPUTY SHERIFF [Faint text]		96. SIGNATURE OF DEPUTY CORONER [Faint text]	
97. SIGNATURE OF DEPUTY CLERK [Faint text]		98. SIGNATURE OF DEPUTY JURY [Faint text]	
99. SIGNATURE OF DEPUTY JUDGE [Faint text]		100. SIGNATURE OF DEPUTY SHERIFF [Faint text]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2821

CERTIFICATE OF DEATH

02841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1305 President St.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harry Bell McNew</i>				4. DATE OF DEATH Month Day Year <i>3-10-1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 4-1918</i>		9. AGE (In years last birthday) <i>41</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Walter McNew</i>				14. MOTHER'S MAIDEN NAME <i>Alice R. Hyde</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes WWII</i>		16. SOCIAL SECURITY NO. <i>WWI</i>		17. INFORMANT Address <i>Doris E. McNew</i>		(2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>1 Hour</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 1957</i> to <i>10 MAR 1960</i> , that I last saw the deceased alive on <i>10 MAR 1960</i> , and that death occurred at <i>930 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Franklin St Annapolis Md</i> DATE SIGNED <i>3/11/60</i>							
ACTUAL SIGNATURE <i>Edward J. Beck</i> M.D.				PHYSICIAN'S NAME (Type) <i>Annapolis Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-13-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jean M. Taylor</i> ADDRESS <i>Annapolis Md</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 14 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached and used as the burial-transit permit. Then please remove carbon 3 and 4 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3851

1. NAME OF DECEASED A. LAST B. FIRST C. MIDDLE		2. SEX A. MALE B. FEMALE		3. AGE A. YEARS B. MONTHS C. DAYS	
4. DATE OF DEATH A. YEAR B. MONTH C. DAY		5. TIME OF DEATH A. HOUR B. MINUTE C. SECOND		6. PLACE OF DEATH A. HOME B. HOSPITAL C. OTHER	
7. CITY OF DEATH		8. COUNTY OF DEATH		9. STATE OF DEATH	
10. OCCUPATION OF DECEASED		11. CAUSE OF DEATH A. DISEASE B. INJURY C. OTHER		12. MANNER OF DEATH A. NATURAL B. ACCIDENTAL C. SUICIDE D. HOMICIDE	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESS		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF WITNESS		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF WITNESS		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF WITNESS		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESS		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF WITNESS		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESS		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESS		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF WITNESS		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESS		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF WITNESS		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF WITNESS		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF WITNESS		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF WITNESS		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESS		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESS		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESS		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF WITNESS		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESS		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF WITNESS		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF WITNESS		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESS		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF WITNESS		102. SIGNATURE OF DECEASED	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CITY OF DEATH
8. COUNTY OF DEATH
9. STATE OF DEATH
10. OCCUPATION OF DECEASED
11. CAUSE OF DEATH
12. MANNER OF DEATH
13. SIGNATURE OF DECEASED
14. SIGNATURE OF WITNESS
15. SIGNATURE OF DECEASED
16. SIGNATURE OF DECEASED
17. SIGNATURE OF WITNESS
18. SIGNATURE OF DECEASED
19. SIGNATURE OF DECEASED
20. SIGNATURE OF WITNESS
21. SIGNATURE OF DECEASED
22. SIGNATURE OF DECEASED
23. SIGNATURE OF WITNESS
24. SIGNATURE OF DECEASED
25. SIGNATURE OF DECEASED
26. SIGNATURE OF WITNESS
27. SIGNATURE OF DECEASED
28. SIGNATURE OF DECEASED
29. SIGNATURE OF WITNESS
30. SIGNATURE OF DECEASED
31. SIGNATURE OF DECEASED
32. SIGNATURE OF WITNESS
33. SIGNATURE OF DECEASED
34. SIGNATURE OF DECEASED
35. SIGNATURE OF WITNESS
36. SIGNATURE OF DECEASED
37. SIGNATURE OF DECEASED
38. SIGNATURE OF WITNESS
39. SIGNATURE OF DECEASED
40. SIGNATURE OF DECEASED
41. SIGNATURE OF WITNESS
42. SIGNATURE OF DECEASED
43. SIGNATURE OF DECEASED
44. SIGNATURE OF WITNESS
45. SIGNATURE OF DECEASED
46. SIGNATURE OF DECEASED
47. SIGNATURE OF WITNESS
48. SIGNATURE OF DECEASED
49. SIGNATURE OF DECEASED
50. SIGNATURE OF WITNESS
51. SIGNATURE OF DECEASED
52. SIGNATURE OF DECEASED
53. SIGNATURE OF WITNESS
54. SIGNATURE OF DECEASED
55. SIGNATURE OF DECEASED
56. SIGNATURE OF WITNESS
57. SIGNATURE OF DECEASED
58. SIGNATURE OF DECEASED
59. SIGNATURE OF WITNESS
60. SIGNATURE OF DECEASED
61. SIGNATURE OF DECEASED
62. SIGNATURE OF WITNESS
63. SIGNATURE OF DECEASED
64. SIGNATURE OF DECEASED
65. SIGNATURE OF WITNESS
66. SIGNATURE OF DECEASED
67. SIGNATURE OF DECEASED
68. SIGNATURE OF WITNESS
69. SIGNATURE OF DECEASED
70. SIGNATURE OF DECEASED
71. SIGNATURE OF WITNESS
72. SIGNATURE OF DECEASED
73. SIGNATURE OF DECEASED
74. SIGNATURE OF WITNESS
75. SIGNATURE OF DECEASED
76. SIGNATURE OF DECEASED
77. SIGNATURE OF WITNESS
78. SIGNATURE OF DECEASED
79. SIGNATURE OF DECEASED
80. SIGNATURE OF WITNESS
81. SIGNATURE OF DECEASED
82. SIGNATURE OF DECEASED
83. SIGNATURE OF WITNESS
84. SIGNATURE OF DECEASED
85. SIGNATURE OF DECEASED
86. SIGNATURE OF WITNESS
87. SIGNATURE OF DECEASED
88. SIGNATURE OF DECEASED
89. SIGNATURE OF WITNESS
90. SIGNATURE OF DECEASED
91. SIGNATURE OF DECEASED
92. SIGNATURE OF WITNESS
93. SIGNATURE OF DECEASED
94. SIGNATURE OF DECEASED
95. SIGNATURE OF WITNESS
96. SIGNATURE OF DECEASED
97. SIGNATURE OF DECEASED
98. SIGNATURE OF WITNESS
99. SIGNATURE OF DECEASED
100. SIGNATURE OF DECEASED
101. SIGNATURE OF WITNESS
102. SIGNATURE OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02842

2822

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 4 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Glen Burnie		f. STREET ADDRESS 16 Greenway, N.W.	
3. NAME OF DECEASED (Type or print) First Geraldine Middle M. Last MIEDEL				4. DATE OF DEATH Month March Day 25 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/1914	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 45 Days 1 Hours 1 Min. 1		11. IF UNDER 24 HRS. Months 45 Days 1 Hours 1 Min. 1		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing				10b. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME George J. Miedel				14. MOTHER'S MAIDEN NAME Anna Sorge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 300-18-2287		17. INFORMANT Mrs. Anna Miedel (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive enterobothric cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 15 hrs. 15 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/24 1960 , to 3/25 1960 , that (I) (we) last saw the deceased alive on Mar. 24, 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE <i>John L. Hedeman</i>				22b. DATE 3/25/60		22c. PHYSICIAN'S NAME (Type) John L. Hedeman	
22d. ADDRESS 121 Cathedral St., Annapolis, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/28/60		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edward G. Funk</i>				25a. REC'D BY REGISTRAR Glen Burnie, Maryland		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

1
X
M
063
1
0
1
B.P.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2823
CERTIFICATE OF DEATH
02843

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle MILLER Last MILLER				4. DATE OF DEATH Month March Day 25 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 23, 1876	
9. AGE (In years last birthday) 83 yrs.		10. UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator (ret)				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel			
13. FATHER'S NAME William H. Miller				14. MOTHER'S MAIDEN NAME Josephine McElliot			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. Nellie Miller		Address Same As. #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V.D. DUE TO (c) Arteriosclerotic C.V.D. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema						INTERVAL BETWEEN ONSET AND DEATH 12 hr. yes.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 24, 1960 to Mar. 25, 1960 , that (I) (we) last saw the deceased alive on Mar. 25, 1960 , and that death occurred at 11:20 A. M, from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley				22b. DATE SIGNED 11:20 A.		22c. PHYSICIAN'S NAME (Type) Frank M. Shipley	
22d. ADDRESS 121 Cathedral St., Annapolis, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 28th March '60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Brooklyn, RFD, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. F. Singleton				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAR 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

CERTIFICATE OF DEATH

Name of deceased: _____
Age: _____
Sex: _____
Date of death: _____
Place of death: _____
Cause of death: _____
Occupation: _____
Signature of physician: _____
Signature of registrar: _____

Witnesses: _____
Signature of witnesses: _____
Date: _____

Registrar: _____
Signature of registrar: _____
Date: _____

Signature of deceased: _____
Date: _____

Signature of family: _____
Date: _____

Signature of community: _____
Date: _____

Signature of church: _____
Date: _____

Signature of school: _____
Date: _____

2824
CERTIFICATE OF DEATH

Reg. Dist. No.

02844

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>F</u> Last <u>MORRIS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7, 1901</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Yacht Capt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Yacht</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>261 20 0676</u>	
17. INFORMANT <u>Mrs. Judith E. Morris- Wife same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 MAR</u> , 19 <u>60</u> , to <u>20 MAR</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>20 MAR</u> , 19 <u>60</u> , and that death occurred at <u>30 P</u> .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edward S Beck</u> M.D. PHYSICIAN'S NAME (Type) <u>Edward S. Beck MD</u> <u>41 Southgate Ave. Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Mar. 22, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Carling S. Hume</u>	
ADDRESS <u>Annapolis, Md.</u>		DATE <u>MAR 24 '60</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1-8-34

CERTIFICATE OF DEATH

I, the undersigned, being a duly qualified Medical Officer of Health for the District of Columbia, do hereby certify that

X

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ARCO.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS - MD.</u>		c. LENGTH OF STAY IN lb <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS - MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL.</u>			d. STREET ADDRESS <u>327 West. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Helen</u>			4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1899</u>		9. AGE (in years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Peter Ksepka</u>			14. MOTHER'S MAIDEN NAME <u>Josephine Glinka</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-42-4963</u>		17. INFORMANT <u>Joseph. NOVAK - ANNAPOLIS - MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>522X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>35 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Churhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/28/60</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-1-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	
				22d. LOCATION (City, town, or county) (State) <u>German Hill Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA 2829 Hudson St. 24, Md.</u>			24a. REC'D BY REGISTRAR <u>APR 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

2826

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02846

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1204 Tyler Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle M. Last O'DAY		4. DATE OF DEATH Month March Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard W. Ward		14. MOTHER'S MAIDEN NAME Sarah E. Ball	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -- --		16. SOCIAL SECURITY NO. 217-16-8888	
17. INFORMANT Mr James F. O'Day - Husband - same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA OF UTERUS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 6 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 1959 to 13 MAR 1960 , that (I) (we) last saw the deceased alive on 13 MAR 1960 , and that death occurred at 8:25A M, from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 3-14-60	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 41 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 15, 1960	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland	
25a. REC'D BY REGISTRAR MAR 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2825

Name of Deceased

Age

Sex

Date of Birth

Date of Death

Place of Birth

Place of Death

Height

Weight

Color

Marital Status

Occupation

Education

Usual Residence

Place of Residence

City

County

Signature

Physician

Medical Examiner

Coroner

19

19



State of New York

Department of Health

Bureau of Vital Statistics

Office of the Registrar

Albany, New York

19

2878

CERTIFICATE OF DEATH

02847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothidn</i>		c. LENGTH OF STAY IN 1b <i>81 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Adelaide</i> First Middle Last <i>Owens</i>		4. DATE OF DEATH Month <i>March</i> Day <i>19</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14 1878</i>
9. AGE (In years last birthday) <i>81</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Bolt. City Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph</i>		14. MOTHER'S MAIDEN NAME <i>Eud Shepherd</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Knob with cardiac failure</i> <i>260x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>Diabetes mellitus</i> DUE TO (c) <i>generalized arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>here</i> , 19 <i>50</i> , to <i>March</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>March 18</i> , 19 <i>60</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Lenny H. Wilson</i> M.D. <i>Lothian, Md.</i> <i>3-21-60</i>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>3/21/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>	22d. LOCATION (City, town, or county) (State) <i>West River Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Hardaway</i>		ADDRESS <i>Lithonia, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 24 60</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

•

2879

CERTIFICATE OF DEATH

02849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>				c. LENGTH OF STAY IN 1b <u>lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Shady Side</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Chester</u> First <u>Phipps</u> Middle <u></u> Last				4. DATE OF DEATH <u>March</u> Month <u>6</u> Day <u>1960</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14, 1906</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>White Jacket Yard</u>			
11. BIRTHPLACE (State or foreign country) <u>Churston, Md</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Edward Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Randall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>316 185877</u>			
17. INFORMANT <u>Blanche Linton Phipps</u> Address <u>Shady Side, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> (c) <u>Hypertensive cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH: <u>immediate</u> <u>3 hours</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>59</u> , to <u>March 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 6</u> , 19 <u>60</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				DATE SIGNED <u>3/8/60</u>			
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>				<u>SHADY SIDE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard W. Hardesty</u> ADDRESS <u>Salisbury</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>MAR 11 '60</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text, possibly "John Doe"]		2. SEX [Faint text, possibly "Male"]	
3. AGE [Faint text, possibly "45 years"]		4. DATE OF BIRTH [Faint text, possibly "Jan 15, 1880"]	
5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		6. OCCUPATION [Faint text, possibly "Teacher"]	
7. MARITAL STATUS [Faint text, possibly "Married"]		8. DATE OF MARRIAGE [Faint text, possibly "June 1, 1910"]	
9. NAME OF WIFE [Faint text, possibly "Jane Doe"]		10. NAME OF HUSBAND [Faint text, possibly "John Doe"]	
11. CAUSE OF DEATH [Faint text, possibly "Heart disease"]		12. PLACE OF DEATH [Faint text, possibly "Home"]	
13. DATE OF DEATH [Faint text, possibly "Dec 10, 1925"]		14. TIME OF DEATH [Faint text, possibly "10:30 AM"]	
15. SIGNATURE OF PHYSICIAN [Faint signature]		16. SIGNATURE OF REGISTRAR [Faint signature]	
17. NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]		18. NAME OF REGISTRAR [Faint text, possibly "John Doe"]	
19. ADDRESS OF PHYSICIAN [Faint text, possibly "123 Main St, Baltimore, Md."]		20. ADDRESS OF REGISTRAR [Faint text, possibly "456 Main St, Baltimore, Md."]	

MAILED JAN 13 1926

RECEIVED
 JAN 13 1926
 BALTIMORE, MD.
 DEPARTMENT OF HEALTH
 OFFICE OF THE REGISTRAR
 100 N. CALVERT ST.
 BALTIMORE, MD.

2880

CERTIFICATE OF DEATH

02850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland			c. LENGTH OF STAY IN 1b 7 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1913 Dorsey Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Louis Middle Nelson Last Purper			4. DATE OF DEATH Month March Day 7 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1938		9. AGE (In years last birthday) 21 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? United States			13. FATHER'S NAME William Purper, Sr.		
14. MOTHER'S MAIDEN NAME Matilda Zachman			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. None			INFORMANT Father Address Same as 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Asthenia 744.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Muscular Dystrophy DUE TO (c) 13 years					INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3/6/60 , 19____, to 3/7/60 , 19____, that I last saw the deceased alive on 3/7/60 , 19____, and that death occurred at 8 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3/8/60 DATE SIGNED ACTUAL SIGNATURE Gustave H. Faubert M.D. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D. 5 - 1st Ave. Glen Burnie, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-10-60	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR PAR 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH



1. Name of deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Cause of death: _____

5. Signature of physician: _____

6. Signature of registrar: _____

7. Signature of informant: _____

8. Date of registration: _____

9. Place of registration: _____

10. Signature of registrar: _____

11. Signature of informant: _____

12. Signature of registrar: _____

13. Signature of informant: _____

14. Signature of registrar: _____

15. Signature of informant: _____

16. Signature of registrar: _____

17. Signature of informant: _____

18. Signature of registrar: _____

19. Signature of informant: _____

20. Signature of registrar: _____

21. Signature of informant: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2881

CERTIFICATE OF DEATH

Reg. Dist. No.

02851

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA				c. LENGTH OF STAY IN 1b 6 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 7, Box 87 PASADENA MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE P. RAAB.				4. DATE OF DEATH Month Day Year MARCH 16, 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 31, 1884		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTER.		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE RAAB				14. MOTHER'S MAIDEN NAME LOUISA. PAUL.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. INFORMANT		Address JOHN RAAB RT 7 BOX 87 PASADENA MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, St. lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 15, 1959 , to March 15, 1960 , that I last saw the deceased alive on March 16, 1960 , and that death occurred at 10 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Benjamin I. Siegel M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 15 Greenleaf Rd, Baltimore 3/18/60			
PHYSICIAN'S NAME (Type) BENJAMIN I. SIEGEL M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 19, 1960		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM.		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Sassahn Funeral Home 7401 Belair Rd #6.				24a. REC'D BY REGISTRAR DATE MAR 21 '60		24b. REGISTRAR'S SIGNATURE Carlton S. Evans	

RAYMOND A. GUNDEL, JR., 18

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the State Board of Health file for burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2828
CERTIFICATE OF DEATH

64135

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Colleen Middle Patrice Last RANDALL		4. DATE OF DEATH Month March Day 29 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 23 47
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter RANDALL, Jr.		14. MOTHER'S MAIDEN NAME Gertrude Lucille PARKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 28, 1960 , to Mar. 29, 1960 , that (I) (we) last saw the deceased alive on Mar. 29, 1960 , and that death occurred at 1:55 P. M, from the causes and on the date stated above.			
22a. SIGNATURE R. L. Richardson		22b. DATE SIGNED 3/30/60	
22c. PHYSICIAN'S NAME (Type) R. L. Richardson		22d. ADDRESS 110 Clay St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-31-60	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill
23d. LOCATION (City, town, or county) Annapolis Md		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Shelley Reese, Jr. Annapolis, Md.		25a. REC'D BY REGISTRAR APR 13 '60	
ADDRESS 2063172xV2		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

01115

CERTIFICATE OF DEATH

2828

X 7767

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Date of Death	
Cause of Death		Manner of Death		Place of Death	
Signature of Physician		Signature of Registrar		Signature of Witness	
Date of Entry		Place of Entry		Signature of Entry Clerk	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2829 **CERTIFICATE OF DEATH**

02852

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle LEE Last ROGERS				4. DATE OF DEATH Month March Day 27 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/64		9. AGE (In years lost birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fair Haven Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Franklin Rogers				14. MOTHER'S MAIDEN NAME Isabelle Perry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. John Guiner Shady Side, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 20, 1960 to March 27, 1960 , that (I) (we) last saw the deceased alive on Mar. 27, 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Edwin Davis, Jr.				22b. DATE SIGNED 4:55 P.			
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr.				22d. ADDRESS 98 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/30/60		23c. NAME OF CEMETERY OR CREMATORY Lusk		23d. LOCATION (City, town, or county) (State) Salisbury Md	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard O. Hardisty Salisbury, Md				25a. REC'D BY REGISTRAR DATE APR 4 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Board of Health pursuant to burial, cremation, or removal, and in any event within 72 hours after death.

063

I

0

BP

2828

MAINTENANCE OF RECORDS OF DEATHS
DEPARTMENT OF HEALTH
DISTRICT OF COLUMBIA
2828



[Faint, mostly illegible handwritten text, likely a death certificate or record, covering the majority of the page.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Board of Health for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed with the State Board of Health for use as the burial-transit permit, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2882 CERTIFICATE OF DEATH

02853

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Christine DuBois Sands</u> First Middle Last 4. DATE OF DEATH <u>3/3/60</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Feb. 24, 1879</u> 9. AGE (In years lost birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint Manf.</u> 11. BIRTHPLACE (State or foreign country) <u>Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob W. DuBois</u>		14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213 32 7840</u> 17. INFORMANT <u>Wm H. Sands</u> Address <u>P.O. Box 22</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>445X</u> DUE TO <u>Acute Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO <u>3 years</u> (c) <u>Hypertension</u> DUE TO <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1956</u> to <u>March 3, 1960</u> that (I) (we) last saw the deceased alive on <u>March 2, 1960</u> and that death occurred at <u>1301</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>DR. JOSEPH LIPSKEY</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/3/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKEY</u> <u>ODENTON, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 12, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Millersville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

82-20

CERTIFICATE OF DEATH

5885

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

DR. JOSEPH L. GREY
CHIEF OF MEDICAL STAFF

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Stanley C. Sargeant</u>		4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21 1921</u>
9. AGE (In years last birthday) <u>38</u> yrs.	10. IF UNDER 1 YEAR Months <u>3</u> Days <u>21</u>	11. IF UNDER 24 HRS. Hours <u>38</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Doctor (M.D.)</u>		<u>State Hospital</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>New Haven Conn.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Sargeant</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Liburd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes WWII</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clara B. Sargeant</u>		Address <u>St. 1 Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation - Hungering</u> <u>974 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self in basement</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Carl Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Carl Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>MAR. 21 - 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>3-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Hamden Plains</u>		<u>Hamden, Conn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese</u>		ADDRESS <u>12 Annapolis, Md.</u>	
24a. REG'D BY REGISTRAR <u>MAR 23 1960</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

82502

Form with multiple sections for medical examination and death certification, including checkboxes for various conditions and fields for dates and times.

1. DEATH CERTIFICATE

2. MEDICAL HISTORY

3. PHYSICAL EXAMINATION

4. LABORATORY EXAMINATIONS

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SIGNATURES

8. NOTES

2884

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4mo. 9 yrs 16days				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) roster				First Satterfield				Middle Satterfield				Last Satterfield				4. DATE OF DEATH Month 3 Day 6 Year 19 60											
5. SEX Male				6. COLOR OR RACE Negro				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH June 6, 1896				9. AGE (In years last birthday) 63 yrs.				10. IF UNDER 1 YEAR Months 63 Days 6 Hours 19 Min. 60							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.															
13. FATHER'S NAME Henry Satterfield				14. MOTHER'S MAIDEN NAME Florence EDMONDS																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-01-0481				INFORMANT Hospital Records				Address															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary & Generalized Arteriosclerosis DUE TO (c)																INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome with Central Nervous System Syphilis																											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----																							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from 10/20 , 19 50 , to 3/6 , 19 60 , that I last saw the deceased alive on 3/6 , 19 60 , and that death occurred at 7:10 A.M. , from the causes and on the date stated above.																											
ACTUAL SIGNATURE L. Benedict, M. D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.				DATE SIGNED 3/7/60																			
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				ADDRESS Crownsville State Hospital, Md.				DATE SIGNED 3/7/60																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/11/60				22c. NAME OF CEMETERY OR CREMATORY Andrew Farmer				22d. LOCATION (City, town, or county) (State) clover, Va.															
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Chalmers				ADDRESS 1701 17th St. N.W.				24a. REC'D BY REGISTRAR MAR 9 '60				24b. REGISTRAR'S SIGNATURE Carlton S. House															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2885

CERTIFICATE OF DEATH

Reg. Dist. No.

02856

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>WORCESTER</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>				c. LENGTH OF STAY IN 1b <i>39 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CROWNVILLE STATE HOSPITAL</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>ELIZABETH SCHOLFIELD</i>				4. DATE OF DEATH Month Day Year <i>MARCH 18 1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1891</i>	9. AGE (In years lost birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>SOUTH CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>NICK HABERSHAM</i>				14. MOTHER'S MAIDEN NAME <i>CHARLOTTE (UNKNOWN)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		INFORMANT Address <i>HOSPITAL RECORDS</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c) <i>generalized a cerebral arterio sclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 week since admission</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>chronic brain syndrome associated cerebral arterio sclerosis & hypertension</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>February 8, 1960</i> to <i>March 19, 1960</i> ; that I last saw the deceased alive on <i>3/18/60</i> , 19 <i>60</i> , and that death occurred at <i>2:45 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Hennrich</i>				ADDRESS (Street, city or town, state) <i>CROWNVILLE STATE HOSPITAL</i>			
PHYSICIAN'S NAME (Type) <i>L. BENEDICT M.D.</i>				M.D. <i>CROWNVILLE, MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-27-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ann Arundel County</i>		22d. LOCATION (City, town, or county) (State) <i>Pocomoke MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hennrich</i>				ADDRESS <i>Pocomoke, MD</i>		24a. REC'D BY REGISTRAR <i>28 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>William S. K...</i>			

010

2

1

BP

CERTIFICATE OF DEATH

286

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon page 4. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
2830
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02857

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle GESTRUDE Last SCHULTZ				4. DATE OF DEATH Month March Day 9 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1897		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES NICHOLS				14. MOTHER'S MAIDEN NAME CORA TURNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT EDWARD G. SCHULTZ		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Aortic myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 22 hrs. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 55 , to Mar. 8 19 60 , that (I) (we) last saw the deceased alive on Mar. 8 19 60 , and that death occurred 2:40 AM , from the causes and on the date stated above.							
22a. SIGNATURE John L. Hedeman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/10/60	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-12-60		23c. NAME OF CEMETERY OR CREMATORY BALDWIN MEMORIAL		23d. LOCATION (City, town, or county) (State) MILLERSVILLE MD	
24. FUNERAL DIRECTOR'S SIGNATURE John M. G. For & Sons Annapolis				25a. REC'D BY REGISTRAR DATE MAR 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

063

1

0

1

133

CERTIFICATE OF DEATH

2883

Place of Death

Place of Birth

Age at Death

Sex

Place of Burial

Place of Burial

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Registrar

Signature of Registrar

Signature of Registrar

THOMAS RICHARDS

COLEMAN RICHARDS
FARMER & SONS

Signature of Registrar

Signature of Registrar

THOMAS RICHARDS
FARMER & SONS

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 3 and 2 should be filed with the State Board of Health for a burial, cremation, or removal, and in any event, within 72 hours after death.

1
2831
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02858

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital (D.O.A.)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 10 Monticello Ave.,							
3. NAME OF DECEASED (Type or print)		First Middle Last Rebecca Mary SLAFKOSKY		4. DATE OF DEATH Month Day Year March 10 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1958		9. AGE (In years lost birthday) 2 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alexander Leonard SLAFKOSKY				14. MOTHER'S MAIDEN NAME Margaret Mary EOFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Palsy with Degeneration 351X DUE TO Congenital Cerebral Defect - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anoxia secondary to Accidental Suffocation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH BIRTH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1958 to March 1960 , that (I) (we) last saw the deceased alive on January 1960 , and that death occurred at 4:10 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Philip Briscoe		22b. DATE 3/11/60		22c. PHYSICIAN'S NAME (Type) Philip Briscoe		22d. ADDRESS 95 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 12, 1960		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR MAR 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

1

AP

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

John A. Smith

White

Male

Single

Married

2-1-19

1919

John A. Smith (U. A.)

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

100-1-1-1-1-1

2886

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE A.A. b. COUNTY MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINSTEAD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LINSTEAD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sullivan J.		d. STREET ADDRESS SULLIVAN J.	
3. NAME OF DECEASED (Type or print) GRACE R. SLAIGHT First Middle Last		4. DATE OF DEATH 3-15-60 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-99 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Geo. M. Boone		14. MOTHER'S MAIDEN NAME Katherine Laphores	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. FAMILY NAME	
17. INFORMANT FAMILY NAME Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatous DUE TO (c) Carcinoma of breast		INTERVAL BETWEEN ONSET AND DEATH 6 hrs 8 hrs 8 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 Mar , 19 60 , to 15 Mar , 19 60 , that I last saw the deceased alive on 15 Mar , 19 60 , and that death occurred at 2:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 715 Cotton Rd. Glen Burnie, Md. DATE SIGNED 15 Mar '60			
ACTUAL SIGNATURE Gene M. Tietjen		PHYSICIAN'S NAME (Type) M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 15-60		22b. DATE THEREOF 3-18-60	
22c. NAME OF CEMETERY OR CREMATORY Belington		22d. LOCATION (City, town, or county) (State) Belington Va	
23. FUNERAL DIRECTOR'S SIGNATURE McElroy-1300 Fort 405		24a. REC'D BY REGISTRAR MAR 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneary			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

02860

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herbert Middle Edward Last SMITH				4. DATE OF DEATH Month March Day 13 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1891	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Smith				14. MOTHER'S MAIDEN NAME Sally Henson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (b); or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Herbert Smith Jr. Bristol Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HASCD DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 10 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/29 19 59 to 3/13 19 60 , that (I) (we) lost saw the deceased alive on 3/13 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Edwin Davis, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-14-60	
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr.				22d. ADDRESS 98 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-18-1960		23c. NAME OF CEMETERY OR CREMATORY Moses		23d. LOCATION (City, town, or county) (State) Brewery Md	
24. FUNERAL DIRECTOR'S SIGNATURE William Beesett				ADDRESS Annapolis		25a. REC'D BY REGISTRAR DATE MAR 16 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

CERTIFICATE OF DEATH

2832

1

WIDE IN
JAN 10 1902
JAN 10 1902
JAN 10 1902

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2833

CERTIFICATE OF DEATH

02861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>10</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>43 Southgate Ave.</u>				d. STREET ADDRESS <u>43 Southgate Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>SNYDER</u> Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept, 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mr Benj. Snyder; Husband; same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>3/15</u> , 19 <u>60</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:00 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3/16/60</u>							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				PHYSICIAN'S NAME (Type) <u>Edward S. Beck MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 16, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

111

CERTIFICATE OF DEATH

Reg. Dist. No.

2887

02862

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXX Pasadena				c. LENGTH OF STAY IN 1b 9 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ventnor				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HAROLD Middle E. Last STEINACKER				4. DATE OF DEATH Month March Day 17 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1st. Jan. 1902	
9. AGE (In years lost birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Stat. Engineer				10b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.			
13. FATHER'S NAME Edward Steinacker				14. MOTHER'S MAIDEN NAME Anna Grimm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 212 05 7280			
17. INFORMANT Mrs. Margaret L. Steinacker				Address Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the lungs 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I attended the deceased from March 1, 1960 to March 17, 1960 , that I last saw the deceased alive on March 16, 1960 , and that death occurred at 3 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. M. McLaughlin				ADDRESS (Street, city or town, state) RD 8 Box 442 Pasadena, Md.			
DATE SIGNED Mar 17 1960							
PHYSICIAN'S NAME (Type) R. M. McLaughlin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 21st. March '60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Singleton				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAR 22 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See, Ill. 101

NAME OF DECEASED ALBERTA L. BROWN		SEX F		AGE 45		RACE W		PLACE OF BIRTH ALABAMA	
DATE OF DEATH JAN 15 1950		TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL HISTORY HYPERTENSION		PREVIOUS ILLNESS YES		OCCASION OF DEATH WHILE AT HOME	
SIGNATURE OF PHYSICIAN J. H. BROWN		SIGNATURE OF WITNESS J. H. BROWN		SIGNATURE OF DECEASED ALBERTA L. BROWN		SIGNATURE OF NEAREST RELATIVE J. H. BROWN		SIGNATURE OF CORONER J. H. BROWN	
DATE OF SIGNATURE JAN 15 1950		DATE OF SIGNATURE JAN 15 1950		DATE OF SIGNATURE JAN 15 1950		DATE OF SIGNATURE JAN 15 1950		DATE OF SIGNATURE JAN 15 1950	

1

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 10-15-2000 BY 60322 UCBAW/STP

2834

Item 8 Film G260 4-7-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02863

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>25 Randall St.</i>				e. STREET ADDRESS <i>25 Randall</i>			
3. NAME OF DECEASED (Type or print) First <i>Elmer</i> Middle <i>Stewart</i> Last <i>Stewart</i>				4. DATE OF DEATH Month <i>Mar</i> Day <i>30</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 31 - 1869</i>	9. AGE (In years last birthday) <i>91</i> yrs.	IF UNDER 1 YEAR Months <i>5</i> Days <i>17</i> Hours <i>1</i> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer Ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at 757 Academy</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>William Stewart</i>				14. MOTHER'S MAIDEN NAME <i>Alice Ford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Frank Siatowski</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> Cerebro-Vascular Hemorrhage DUE TO <i>Cerebro-Vascular Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, Generalized</i> DUE TO <i>1771</i> (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar 20</i> , 19 <i>60</i> , to <i>Mar 30</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Mar 30</i> , 19 <i>60</i> , and that death occurred at <i>3:27</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>65 SHAW ST ANNAPOLIS, MD.</i> DATE SIGNED <i>3/31/60</i>							
ACTUAL SIGNATURE <i>James R. Martin</i> M.D.				PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-1-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Lent</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Son</i> ADDRESS <i>Annapolis Md</i>				24a. REC'D BY REGISTRAR DATE <i>APR 1 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 of this certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02864

2835

1. PLACE OF DEATH a. COUNTY <u>D.A.C.O.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANCO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Rural.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Woodland Beach.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. ANNE ARUNDEL GENERAL.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>(Rome) ROME IT</u> Middle <u>CHARLES</u> Last <u>STOFFEL.</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A & P TeaeStore</u>	
11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Henry Stoffel</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Reedy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>219-16-1220</u>	
17. INFORMANT <u>Woodland Beach, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cardiac disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>March 15, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax County, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Durmish</u>		ADDRESS <u>2847 Wilson Blvd., Arlington, Virginia</u>	
24a. REC'D BY REGISTRAR <u>MAR 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64145

2836

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>163 Duke Gloucester</u>				d. STREET ADDRESS <u>163 Duke Gloucester</u>			
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Cully</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6 - 1871</u>		9. AGE (in years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES CULLY</u>				14. MOTHER'S MAIDEN NAME <u>HARRIETT HALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>HARRIET-JASON - 614 N. 56th ST. PHILA. PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Chronic disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> o. m. <u>19</u> p. m. <u></u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Linhart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Linhart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u>				ADDRESS <u>ANNAPOLIS - Md.</u>		24a. REC'D BY REGISTRAR <u>APR 6 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF DEATH	
EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		POSTMORTEM EXAMINATION	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION	
SIGNATURE OF WITNESS		TITLE OF WITNESS		DATE OF WITNESS		PLACE OF WITNESS		TIME OF WITNESS		PLACE OF WITNESS	

2888

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 397 Marley Ave</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Logan Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>A.</u> Middle <u>TAYLOR</u> Last		4. DATE OF DEATH <u>MARCH</u> Month <u>23</u> Day <u>1960</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Goetz's</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW.W. 1 215-01-0478</u>	
17. INFORMANT <u>Mae V. Taylor-wife-Point Pleasant Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal hemorrhage</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Inoperable carcinoma of lung.</u> DUE TO (c) <u>of lung.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 23, 1960</u> to <u>March 23, 1960</u> that I last saw the deceased alive on <u>March 23, 1960</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmond I. Moushabeck</u> M.D. <u>2101 S. Ritchie Highway</u> DATE <u>March 23, 1960</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u> <u>Glen Burnie, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Rd. Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>KRAUSE FUNERAL HOME</u> ADDRESS <u>1216 S. Charles St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the Registrar. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

02/20/01

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2837 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02866

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>58 Larkin St.</u>		d. STREET ADDRESS <u>58 Larkin St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Edward</u> Middle <u>Timmons</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Ch.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-60</u>
9. AGE (In years last birthday) <u>1 mo 21 da.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Timmons</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Porter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Eleanor Porter - Annapolis, Md.</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3560</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u>		22d. LOCATION (City, town, or county) (State) <u>St. Margaret's Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
DATE <u>MAR 14 '60</u>			

NAVY DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
3883

NAVY DEPARTMENT
WASHINGTON
1917

NAME: [illegible]
RANK: [illegible]
REGIMENT: [illegible]
COMPANY: [illegible]
BATTALION: [illegible]
BRANCH: [illegible]
REGIMENTAL HEADQUARTERS: [illegible]
ADDRESS: [illegible]
CITY: [illegible]
STATE: [illegible]
COUNTRY: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DISEASE OR INJURY: [illegible]
PREVIOUS ILLNESS: [illegible]
PREVIOUS INJURY: [illegible]
PREVIOUS SURGERY: [illegible]
PREVIOUS MEDICAL TREATMENT: [illegible]
PREVIOUS MEDICAL HISTORY: [illegible]
PREVIOUS MEDICAL RECORD: [illegible]

PREVIOUS MEDICAL RECORD: [illegible]
PREVIOUS MEDICAL HISTORY: [illegible]
PREVIOUS MEDICAL TREATMENT: [illegible]
PREVIOUS SURGERY: [illegible]
PREVIOUS INJURY: [illegible]
PREVIOUS ILLNESS: [illegible]
DISEASE OR INJURY: [illegible]
MANNER OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
DATE OF DEATH: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DISEASE OR INJURY: [illegible]
PREVIOUS ILLNESS: [illegible]
PREVIOUS INJURY: [illegible]
PREVIOUS SURGERY: [illegible]
PREVIOUS MEDICAL TREATMENT: [illegible]
PREVIOUS MEDICAL HISTORY: [illegible]
PREVIOUS MEDICAL RECORD: [illegible]

PREVIOUS MEDICAL RECORD: [illegible]
PREVIOUS MEDICAL HISTORY: [illegible]
PREVIOUS MEDICAL TREATMENT: [illegible]
PREVIOUS SURGERY: [illegible]
PREVIOUS INJURY: [illegible]
PREVIOUS ILLNESS: [illegible]
DISEASE OR INJURY: [illegible]
MANNER OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
DATE OF DEATH: [illegible]

2838

CERTIFICATE OF DEATH

Reg. Dist. No.

02868

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle R. Last Whittington		4. DATE OF DEATH Month 3 Day 12 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman of Roads		10b. KIND OF BUSINESS OR INDUSTRY A. A. Co. Md.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Whittington		14. MOTHER'S MAIDEN NAME Barbara Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Clarence E. Whittington	
17. INFORMANT Clarence E. Whittington		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 465X DUE TO (c) 465X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic carcinoma			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 3 Day 12 Year 60 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/22 19 60 to 3/12 19 60 , that I last saw the deceased alive on 3/12/60 and that death occurred at 2:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral Street DATE SIGNED 3/12/60			
ACTUAL SIGNATURE Richard N. Peeler M.D.		DATE SIGNED 3/12/60	
PHYSICIAN'S NAME (Type) Richard N. Peeler, M. D.		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 15-1960	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	22d. LOCATION (City, town, or county) (State) Glen Burnie Md
23. FUNERAL DIRECTOR'S SIGNATURE John M. Luper Sons		24a. REC'D BY REGISTRAR MAR 15 '60	24b. REGISTRAR'S SIGNATURE Clarence E. Whittington

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2839

CERTIFICATE OF DEATH

02869

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital				d. STREET ADDRESS 337 Burnside St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle ELIZABETH Last WILHELM				4. DATE OF DEATH Month March Day 23 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 7, 1891	
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JAMES M. EVANS				14. MOTHER'S MAIDEN NAME ELLEN R. CANTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —		17. INFORMANT CATHERINE DOERR Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto Cardiac Failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2-25-60 19 to 3-5-60 19, that (I) (we) last saw the deceased alive on 3-5-60 19, and that death occurred at 7:50 P. M., from the causes and on the date stated above.							
22a. SIGNATURE A. T. Allen				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/24/60	
22c. PHYSICIAN'S NAME (Type) A. T. Allen				22d. ADDRESS 62 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		3-26-60		CEDAR BLUFF		Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE MAR 28 '60	
				25b. REGISTRAR'S SIGNATURE Arthur E. Hanna			

099

1

0

1

BP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME(5)
5/14 9/55

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>3 Vol. 4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN lb <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pla Za Manor Convalescent Home</u>				d. STREET ADDRESS <u>1021 Madison St.</u>			
3. NAME OF DECEASED (Type or print) <u>Elsie Williams</u> First Middle Last				4. DATE OF DEATH <u>March 13th.</u> Month Day Year <u>19 60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/16/1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Barren Banshaw</u>				14. MOTHER'S MAIDEN NAME <u>Ella Coe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Plaza Manor Convalescent Home Records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>3/13/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Bluff Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lee Co., S.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Lewis</u>				ADDRESS <u>1639 N. Broadway</u>		24a. REC'D BY REGISTRAR <u>MAR 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE _____		TIME _____	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. THE FUNERAL DIRECTOR: Pages 1 and 2 of this certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2891

02871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville		c. LENGTH OF STAY IN TB 19 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Galesville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle E. Last WILLIAMS				4. DATE OF DEATH Month March Day 24 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH MAY 21, 1915	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crewman		10b. KIND OF BUSINESS OR INDUSTRY Deport Yacht		11. BIRTHPLACE (State or foreign country) Chesapeake Beach, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. Samuel Williams				14. MOTHER'S MAIDEN NAME Anna Matilda Nelson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 21316 9453		17. INFORMANT Mrs. Lena Hazard, Galesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				DATE SIGNED 3-24-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/60		22c. NAME OF CEMETERY OR CREMATORY Leakner		22d. LOCATION (City, town, or county) (State) Galesville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard O. Hardisty				ADDRESS Galesville		24a. REC'D BY REGISTRAR MAR 29 '60	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

2840

CERTIFICATE OF DEATH

02872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wild Rose Shores</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Finnerty</u> Last <u>Witcher</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Nevada</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Finnerty</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. H. T. Walsh</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>59</u> , to <u>12 MAR</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12 MAR</u> , 19 <u>60</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S Beck</u> M.D. <u>41 Southgate Ave.</u>		DATE SIGNED <u>3/14/60</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S BECK</u>		<u>Annapolis Md</u>	
22a. BURIAL (CREMATION) <u>Cremation</u>	22b. DATE THEREOF <u>3-14-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02873

2832

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>All life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2 S. Bruce St. Barber's Trailer Court</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael Anthony Woodard</u>		4. DATE OF DEATH Month Day Year <u>March 18th. 1960 19</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>2/6/60</u>	
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>12</u> yrs. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Reverdale, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles L. Woodard</u>		14. MOTHER'S MAIDEN NAME <u>Francis Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr and Mrs. C.L. Woodard (parents)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		22. DATE THEREOF <u>3/20/60</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>He Will Dandelion Laurel, Md.</u>		24. REC'D BY REGISTRAR <u>Smithfield N. Carolina</u>	
25. ADDRESS <u> </u>		26. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

W. Bradley King, Jr., M.D.

M.D. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

3/18/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The funeral director should be used as a burial-transit permit. File pages 1 and 2 with the Registrar of Death, cremation, or removal.

VS. A15ME(5)

5M 9/55

Nov 4/1960

2076232XV5

1

1572

Journal of Interpersonal Violence 20(10) 1257-1274